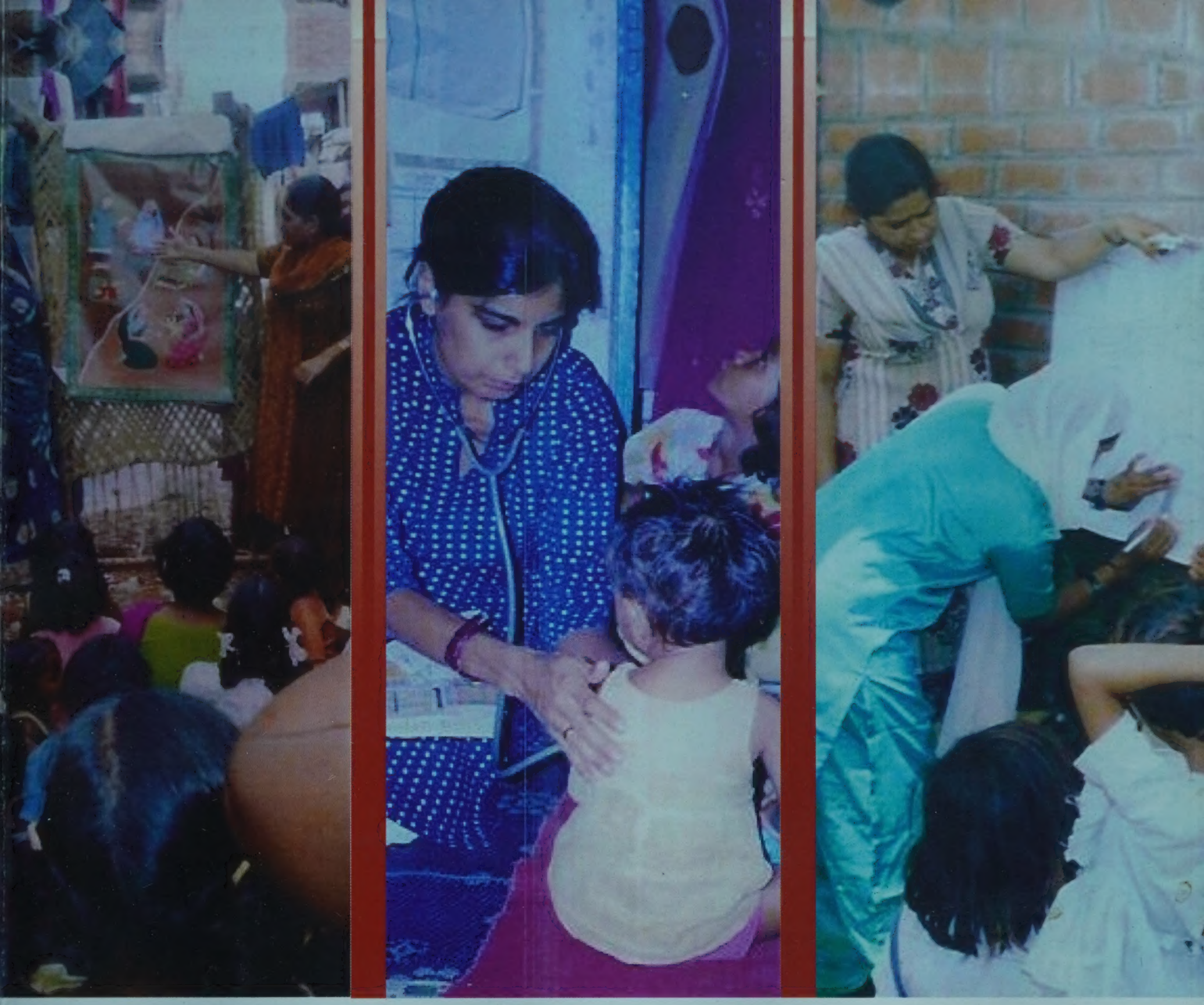

Action for Young Children

MOBILE CRECHES
Nurturing Childhood Sowing Change

"Study of Interventions in Early Childhood Care for Development and Behaviourial Changes in an Urban Resettlement Colony"

2004 - 2007

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CONTENTS

	Page No.
1. INTRODUCTION	1-3
1. I Background	
1.II Area characteristics	
1.III Introduction to Action research	
2. THE ACTION RESEARCH- METHODOLOGY	5-9
2. I Objectives, Process and Key Elements	
2.II Details of the Tools	
2.III Sample	
2.IV Analysis	
3. COMMUNITY ADVOCACY, COMMUNICATION AND NETWORKING	10-13
3.I Activities	
3.II Other Support Activities	
4. IMPACT ON PUBLIC SERVICES	15-16
4.I Impact on ICDS Centres	
4.II Impact on Public Health Services	
5. FINDINGS OF ACTION RESEARCH	17-38
5.I Pre-Intervention	
5.I.a Background Information	
5.I.b Baseline Data	
5.II Post-intervention	
5.II.a Antenatal Care, Delivery, Postnatal Care, Neonatal Health	
5.II.b Immunization	
5.II.c Nutrition and Malnutrition	
5.II.d Impact on Management of Common Illnesses	
5.II.e Development	
6. 2ND ROUND FINDINGS	39-43
7. OTHER SUPPORT ACTIVITIES FOR ACTION RESEARCH	45-46
8. COMPARISON WITH NFHS III	47-49
9. SUMMARY	51-52
10. Annexures	53-108
• Time Line	
• Case Study	
• Forms	

List of Table

Table 1 Target Achievement

List of Figures-

Figure	Topic
Figure 1	Reasons for rejecting the forms
Figure 2	Opening of AWCs in Madanpur Khadar
Figure 3	Monthly Income
Figure 4	Family size
Figure 5	Number of children in each household
Figure 6	Literacy level
Figure 7	Number of previous pregnancies
Figure 8	Age at present
Figure 9	Use of contraceptives
Figure 10	Antenatal care
Figure 11	Place of birth
Figure 12	Place of check-up
Figure 13	Antenatal check-up
Figure 14	Antenatal care
Figure 15	Diet
Figure 16	Place of delivery
Figure 17	Place of Birth
Figure 18	Facilitator for delivery
Figure 19	5 cleans
Figure 20	Sex of the children born
Figure 21	Time period of 1st weight of the child
Figure 22	1st bath after birth
Figure 23	1st bath of the child after birth
Figure 24	Prelacteals
Figure 25	Prelacteals
Figure 26	Colostrum intake
Figure 27	Colostrum intake

Figure 28 Birth registration
Figure 29 Status of immunization at 3.5 months
Figure 30 Status of immunization at 6 months
Figure 31 Immunization at 9 months
Figure 32 Immunization against measles at 12 months
Figure 33 Vitamin A dosage at 9 months
Figure 34 Immunization status
Figure 35 Birth weight
Figure 36 Weight of the children at 15 days
Figure 37 Prelacteals
Figure 38 Exclusive breastfeeding after giving prelacteal
Figure 39 Exclusive breastfeeding
Figure 40 Complementary feeding
Figure 41 complementary feeding
Figure 42 Supplementary food being given to the child at 9 months
Figure 43 Status of nutrition
Figure 44 Status of nutrition
Figure 45 Knowledge of preparing ORS
Figure 46 Knowledge on Diarrhoea
Figure 47 Preparation of Rehydration Solution
Figure 48 Identification of Pneumonia
Figure 49 Percentage of children holding their head at the age of 3 and half months
Figure 50 Development Indicator at 9 months: crawling
Figure 51 Development Indicator at 9 months: sits without support
Figure 52 Development Indicator at 12 months: stands without support
Figure 53 Place for antenatal check-ups
Figure 54 Antenatal care
Figure 55 Diet during pregnancy
Figure 56 Rest
Figure 57 Weight monitoring of mothers
Figure 58 Antenatal care: iron and folic acid intake

Figure 59 Antenatal Care: tetanus injections
Figure 60 Facilitator for delivery
Figure 61 1st bath of the child after birth
Figure 62 Colostrum
Figure 63 Prelacteal
Figure 64 Status of immunization at 6 months
Figure 65 Exclusive breastfeeding till 6 months
Figure 66 Trends in contraceptive use
Figure 67 Trends in any antenatal care
Figure 68 Birth assisted by Doctor/ Nurse/ LHV/ ANM
Figure 69 Children 12-23 months who have received BCG
Figure 70 Children 12-23 months who have received measles vaccine
Figure 71 Children 12-23 months who have received 3 doses of DPT vaccine

EXECUTIVE SUMMARY

Mobile Crèches, an NGO working for early childhood care and development (ECCD) amongst poor urban communities in slums in Delhi, had been using and assessing various centre based interventions in child care, development, health and nutrition for over 38 years. Various studies done during this process, however, reinforced the fact that information and skills related to ECCD continued to be poor amongst the urban poor with resulting negative impact upon the care and health of the very young child. This was further exacerbated by severely inimical socio economic and environmental factors such as the lack of adult carers at home as both parents of the nuclear families went to work, leaving their young in 'sibling care', extreme relative poverty and instability of livelihoods, resulting migration, very poor water and sanitation conditions, exploitation by private health care providers and unresponsive and inaccessible public services. The main strategy used by the organisation has been to provide support in the form of centre based crèches, pre school services and school support services, as well as some community based dissemination of information related to ECCD through mothers' meetings, use of folk media etc. However of late, many new strategies were being tried to get beyond the direct running of centres and supporting communities to use public resources as well as their own to achieve the same goals

In an in-house assessment of the work in a resettlement colony; Madanpur Khadar, it was felt that enough broad based activities had been undertaken in the area and, while continuing such activities, the time was ripe to work intensively on a small group of about 250 families so that behaviour change may be effected and results of proper care of mother and infant could serve as a demonstration of good practice. Since this 'one to one' household level strategy had never been used in MC, it was decided to see it as a piece of 'action research' for organisational learning and potential replication if found useful.

Methodology and Process

After much brainstorming, it was decided that rather than a centre-based approach, a three fold process of community sensitization and advocacy, family based interventions into child care practices and facilitating access to public services would be used. It was thus decided to embark upon three modalities of intervention in favour of ECCD:

1. A planned, systematic, 2 year long household level community health worker based action research (2004-2007)
2. Liaison between the community and health and other related services, as well as to create pressure groups for sustaining and improving this relationship (2003 – ongoing)

3. General community level sensitisation on ECCD issues and widespread dissemination if information to provide and overall favourable environment and support for the previous two interventions (2003 – ongoing).

The 'action research' would 'walk' with women from pregnancy to the time their children were 18 months old to see what practices were being followed in child care, nutrition and health, to make positive interventions and to measure their impact.

The basic method was to be a series of home visits at specified periods with specific observations and tasks to be done at each visit. Each visit would be supported by material, which is referred to as 'form' in subsequent discussions.

About 20 meetings and interactions were held in the community to explain the objectives of the study. A household survey was then conducted in blocks A1, A2, and B1 and pocket C, which had a total of 10,000 population to gather baseline information on health, nutrition and childcare practices during previous pregnancies and with previous children. 270 families were identified during the course of the survey where there were pregnant women and /or young children.

Thirteen forms were developed for the study. The primary purpose of the tools was to support the programme of intervention. However, they would allow measurements of various processes and impact at various stages of the process. Each 'form' for example, comprised of information on what to see, what to do, what to measure and some key messages relevant to that particular form.

Form 1: socio-economic/ background information.
Form 2: based on practices during previous pregnancy.
Form 3: practices during present pregnancy.
Form 4: just after birth.
Form 5: 15 days of age.
Form 6: at the age of 1 and half months.
Form 7: at the age of 2 and half months.
Form 8: at the age of 3 and half to 4 months.
Form 9: at the age of 6 months.
Form 10: at the age of 9 months.
Form 11: at the age of 12 months.
Form 12: at the age of 18 months.

These forms accompanied a growth chart (Unicef), for easy monitoring of growth of the children at regular intervals.

The total number of families included in the survey varied considerably through time from less than 200 to over 300 mostly due to migration and due to addition of families from another site for organisational reasons.

Simultaneously, two other significant processes were embarked upon in the same area as discussed above:

Environment building, sensitisation and capacity building on ECCD issues with the community in general and women's groups in particular, using folk media.

Building community pressure for better services related to ECCD; in particular, the ICDS and the servicing PHC at a nearby village.

These processes resulted in the allocation of an extra ANM to this area for ANC and immunisation as well as the operationalisation of 53 ICDS centres where previously none had existed.

Key Results of Household Level Intervention

The key results of the household level intervention through the team of health workers and supervisors / trainers were as follows:

On the whole, baseline figures of antenatal care showed improvement after intervention with only 9% women receiving no antenatal care as compared to 23% and 58% receiving partial care as compared to 36%.

There was a significant decline in home deliveries without trained birth attendants from 47% to 21%. There was an increase in home deliveries with TBAs from 21% to 44% and a slight (insignificant) increase in institutional deliveries from 32% to 35%. Interestingly, of the children born, 51% were female and there was no evidence of sex selection.

There were distinct gains made as a result of the intervention as compared to the baseline on early bathing of the neonate and immediate bathing was reduced to half, from 70% to 35%. About half the babies born received prelacteals despite advice to the contrary and this figure showed no change as compared to the baseline.

There was a significant improvement in the percentages of babies who received colostrum, from 46% to 70%.

Complete immunisation at 12 months was at 87% as compared to 63.2% for Delhi (NFHS III). Three doses of DPT in children aged 12-23% was 100% as compared to 72% (NFHS III), measles immunisation at age 12-23 months was 85% compared to 78% (NFHS III).
Vitamin A administration increased from 42% to 77%.

Exclusive breast feeding at 6 months was only at 37% compared to 34.5% for Delhi as per NFHS III.

However, many women went on to give nothing but breast milk for varying periods of time after prelacteals were given. Of children who received prelacteal first and then were breast fed, 61% of children received breast feed without any other top feeds till 6 months.

Out of the children who did not receive prelacteals, 77% received exclusive breast feeding for 5-6 months.

It appeared that the message to introduce complimentary food at six months was widely and well received with 80% children receiving it as compared to the baseline of 49%.

Despite these gains, 67% of children were malnourished at 18 months. (Delhi data for NFHS III lies at 33% for under threes).

Knowledge of diarrhoea management and skills for delivering oral rehydration increased from 32% to 80%.
Ability to recognise pneumonia increased from 53% to 89%.

Conclusion

Various strategies have been tried to intervene positively for the health and well being of children by organisations such as Mobile Creches. These include the provision of direct services, working with families for greater awareness on issues related to ECCD, working with communities to provide support for these issues and also facilitating access to Government services and various entitlements.

All these interventions hinge upon the facilitation by person with the requisite skills and knowledge to accomplish these diverse tasks. Clearly, the maximum impact can be expected with the use of multiple strategies rather than a single one.

Short of providing direct services, this 2 year long intervention in an urban resettlement colony used a combination of all these approaches by a team of trained facilitators, supported by a group of trainers including a community child health specialist.

Specially, it was possible to make gains on immunisation and management skills for common diseases. Moderate impact could be seen on colostrum feeding and delaying the first bath of the child. However, little impact could be made seen on issues such as exclusive breast feeding and prevention of malnutrition. Nevertheless, impact which was not reflected in better figures could be seen on a case-by case basis as illustrated by various documented case studies.

The ICDS services in the area could be increased and improved towards the latter phase of this exercise. However, apart from the immunisation services of the ANM, general child health

services remained extremely poor. No major intervention was either planned or made in the overarching determinants of child health and nutrition such as poverty or status of the involved women. However, some efforts are being made to mobilise women and organise them into SHGs. Some efforts were also made to improve the quality of water with poor results.

The results of this intervention now need to be analysed in terms of costs and replicability for future use within the organisation and elsewhere.

1. INTRODUCTION

1. I. Background Information

Community health workers have formed the cornerstone of health interventions in rural communities in India for decades. Well known programmes such as Jamkhed programme, the Gadchiroli programme, the FRCH programme (Pune) and the more recent state wide and state implemented Mitanin programme have led to the creation of the cadre of accredited social and health activists; the ASHA, within the NRHM as one of its core strategies.

However, urban health worker programmes have hardly been documented (with the notable exception of the large scale health worker programme in Kolkota[1]) despite the fact that the status of morbidity and mortality in urban slums has often been observed to be even worse than that found amongst the rural poor. Urban health has also yet to find its space within the government programmes in the same concerted manner as has rural health, though an urban health mission is allegedly in the processes of development. One reason for this gap might be the illusion that because urban areas have a variety of health services, both public and private, an intervention is not really required. It may also be felt that the urban poor have better access to health information through various agencies including the media. However, a task force has been constituted to advise the National Rural Health Mission on strategies for Urban Health Care and an Urban Health Cell has been established in the Ministry of Health and Family Welfare.

Mobile Crèches, an NGO working on early childhood care and development (ECCD) amongst poor urban communities in slums in Delhi, had been using various centre based interventions in child care, development, health and nutrition for over 38 years. Various studies done during this period reinforced the fact that information and skills related to ECCD continued to be poor amongst the urban poor with negative impact upon the care and health of the very young child. This was further exacerbated by inimical socio economic and environmental factors: lack of adult carers at home as both parents of the nuclear families went to work, leaving their young under the care of older 'sibling', extreme poverty and instability of livelihoods, have rates of inter city migration and movement, very poor water and sanitation conditions, exploitation by private health care providers and unresponsive and inaccessible public services.

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1. Kolkota Urban Services For Poor, Interim Support Consultation To The Change Management Unit, Draft Report On HHW Programme Review, November 2004
2. Child care study
3. Sibling care

The main strategy used by the organisation has been to provide support in the form of centre based crèches, pre school services and school support services, as well as some community based dissemination of information related to ECCD through mothers' meetings, use of folk media etc. However, of late, many new strategies were being tried by Mobile Creches to get beyond the direct running of centres and supporting communities to use public resources as well as their own to achieve the same goals.

Mobile Crèches (henceforth MC) had been working with the slum community in Nehru Place for a number of years. As the government started pursuing large scale relocation of slums in Delhi, the slums of Nehru Place also came in for demolition. Like many other community based organizations, MC too was left with little choice but to follow its client community to its next destination, Madanpur Khadar (henceforth MK).

1. II. Area Characteristics

The process of shifting slum populations started in 2000. MK was selected by the Government as the site to relocate large groups of slum dwellers from different parts of the city. Slum dwellers from various part of the city like Nehru Place, Mayur Vihar, Alaknanda, Lajpat Nagar, Hauz Khas, Gautampur, Raj Nagar, found themselves relocated to MK.

As allotment took place, the population moved into an area completely devoid of basic amenities. Water, electricity, paved roads were scarcely in existence. Rains waterlogged the pathways in the absence of sewers and drains. No schools or health care services were in existence. Transport was totally inadequate. Dislocation of work caused major stress and economic hardship for people.

MK is located adjacent to the MK Village only separated by Yamuna distributary. The area is now referred to the J.J. colony housing a huge population divided in to various blocks namely: A-1, A-2, B-1, C pocket, D, etc. each block has houses with different allotment area, ranging from 12 sq.feet to 18 sq.feet.

1. III. Introduction to the Action Research

2003-2005

The immediate response to people's needs was to facilitate improvement in the situation of water and electricity. Issues of school admissions, birth registrations and demand for ICDS centres were also taken up through a team of facilitators. A diarrhoea epidemic provoked training and action in diarrhoea management. As an organization, Mobile Creches had decided that running a creche service in MK would be like a drop in the ocean of need and a

better strategy would be to develop women in the community to provide the service. One of the first interventions, therefore, in 2003, was to create a cadre of trained child care workers and facilitate some home based crèches in the area.

2005; Deepening and widening the base of work in MK.
In-depth work – the beginning of the action research

In an in-house assessment of the work in MK, it was felt that a wide variety of activities had been undertaken in the area focussing on creating awareness and building capacities on ECCD, but the time was ripe to work intensively on a small group of about 250 families. This was necessary to observe and assess the impact of the interventions at one-to-one serve as a demonstration of good practice and could be incorporated as an integral part of organisational learning especially in the context of replication in other situations.

2. THE ACTION RESEARCH; METHODOLOGY

2.1. Objectives, Process and Key Elements

Objectives: There were two driving forces to the action research; one, the challenge, of working in a new area with the purpose of achieving a sizeable impact upon a defined community, and two, to pilot a 'one to one' intervention on child care and child health practices which would be a new element in the organizational strategy of Mobile Crèches.

After much brainstorming, it was decided that rather than a centre-based approach, a three fold process of community sensitization and advocacy, family based interventions into child care practices and facilitating access to public services would be used.

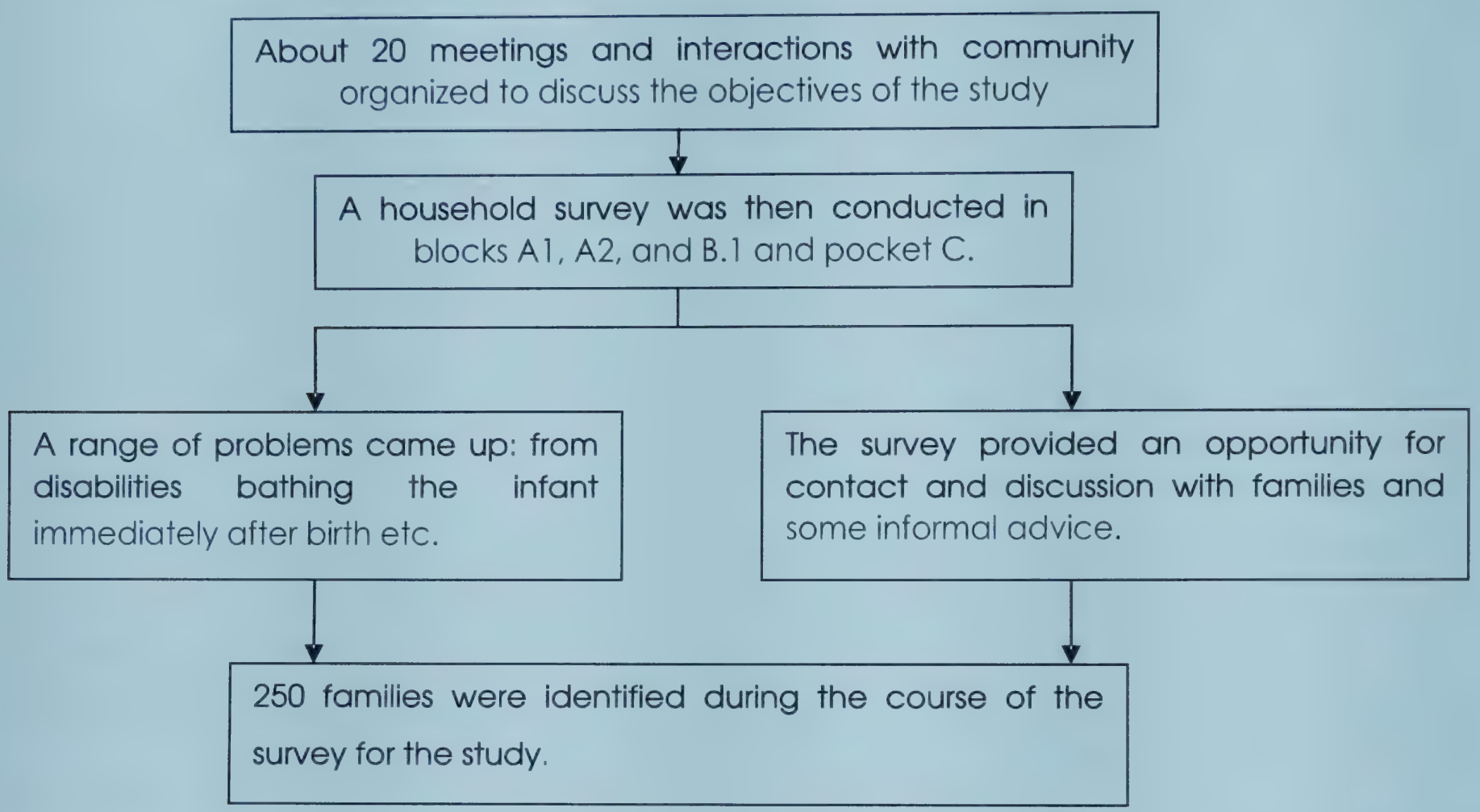
It was thus decided to embark upon three modalities of intervention in favour of ECCD:
1. A systematic, 2 year long household level community health worker based action research (2004-2007)
2. Liaison between the community and health and other related services, as well as creation of pressure groups for sustaining and improving this relationship (2003 – ongoing)
3. General community level sensitisation on ECCD issues and widespread dissemination of information to provide and overall favourable environment and support for the previous two interventions (2003 – ongoing).

The 'action research' would:
'Walk' with women from pregnancy to the time their children were 18 months old to see what practices were being followed in child care, nutrition and health.
To make positive interventions and
To measure their impact.
The 'research' was less for purpose of study (it was not expected to throw up very unusual findings which would differ from subjective collective experience of over 35 years) but to introduce a rigour in the programme and to enable the organization to assess the efficacy and costs of an intervention such as this and prioritise our energies as well as attention. Trained community based health workers would be used for this process along with a team of supervisors/trainers and a consultant with special interest in child health and nutrition.

The **basic method** was to be a series of home visits at specified periods with specific observations and tasks to be done at each visit. Each visit would thus be supported by material, which is referred to as 'form' in subsequent discussions.

A **health consultant** was involved in drawing up the plan of action, training the field staff and facilitators to carry out a focused activity with pregnant women and their children up to three years.

It was also proposed that the processes of sensitization and awareness about **Early Childhood** with the wider community, **networking and advocacy** on children's issues, should not only continue but communication materials and events should be organized to keep up the momentum drawing in a wider circle of the adult population.



Thirteen forms were developed for the study. The above processes – planning, training, local meetings and the development of forms took 4 months, followed by the filling of forms. The objectives of the study were discussed with the **field team** and they received **training** on how to go about the data collection.

The team was also to provide supportive actions: network with PHCs / facilitate immunizations; and check-up of children who are not well in the family groups under study even if they are not part of the study themselves.

The community pediatrician involved with directing the study would provide health checks to all children on a periodic basis as well as form a part of the supervisory and support team for 'on the job' training to the facilitators.

The 250 families identified included:

135 pregnant women

115 children under six months

Interactions/ contacts were established with these 250 families. History of previous pregnancy was taken and issues discussed:

Need to weigh infant immediately after birth,
Defer bathing the child for six days
Problems with pre lacteal feeding
Feeding/ complementary feeding
Need for regular check-ups

A schedule was set-up to follow the pregnancy through and to follow the mother and child soon after birth, at 15 days, one month, 3 months, 6 months, 12 months etc till 2 years. The interventions would not only record data but attempt to ensure that mother and child health is monitored. Immunization, introduction of beneficial feeding practices, regular growth monitoring, hygiene, and socio-emotional support was provided.

2. II. Details of the tool

As discussed above, the primary purpose of the tools was to support the programme of intervention. However, they would allow measurements of various processes and impact at various stages of the process. Each 'form' for example, comprised information on what to see, what to do, what to measure and some key messages relevant to that particular form.

Focus group discussions and general observations were also used to collect baseline information about the community. Many other materials and methods such as street plays, posters and exhibitions were used during the process of community sensitization and advocacy during which a special effort was made to involve households participating in the action research.

Case studies were also done to investigate and highlight specific issues such as child deaths, severe malnutrition and children with chronic or serious diseases.

A series of 12 forms were prepared, which helped in tracing the growth and development of the children from birth to 18 months of age. The forms include the immunization schedule, developmental milestones, antenatal/postnatal care for mothers, diet plans, information on the diseases affecting children and child care practices. They provided a check list of all the topics/ subjects, on which the facilitator required information and with it being in front of him/her the chances of leaving out any thing was minimal. They were devised in such a way that the objectivity of answers obtained would be high and data collected from them easy to analyze, requiring less interpretation.

Thus, in every form, there were key messages to transact, key interventions to make, key observations to record and space to record specific problems and action taken.

The forms were developed during a workshop with the supervisory team, which also served as the first training workshop.

The forms are described below more specifically.
Form 1: socio-economic/ background information.
Form 2: practices during previous pregnancy.
Form 3: practices during present pregnancy.
Form 4: just after birth.
Form 5: 15 days of age.
Form 6: at the age of 1 and half months.
Form 7: at the age of 2 and half months.
Form 8: at the age of 3 and half to 4 months.
Form 9: at the age of 6 months.
Form 10: at the age of 9 months.
Form 11: at the age of 12 months.
Form 12: at the age of 18 months.

These forms accompanied a growth chart (Unicef), for easy monitoring of growth of the children at regular intervals.

2. III. Sample

Subhash Camp was chosen to provide some contrast between an established slum and a new resettlement colony as well as for organizational reasons of creating a pool of trainers of large enough size for the future. Of course, as discussed below, the sample size from Subhash Camp was much smaller than that from MK.

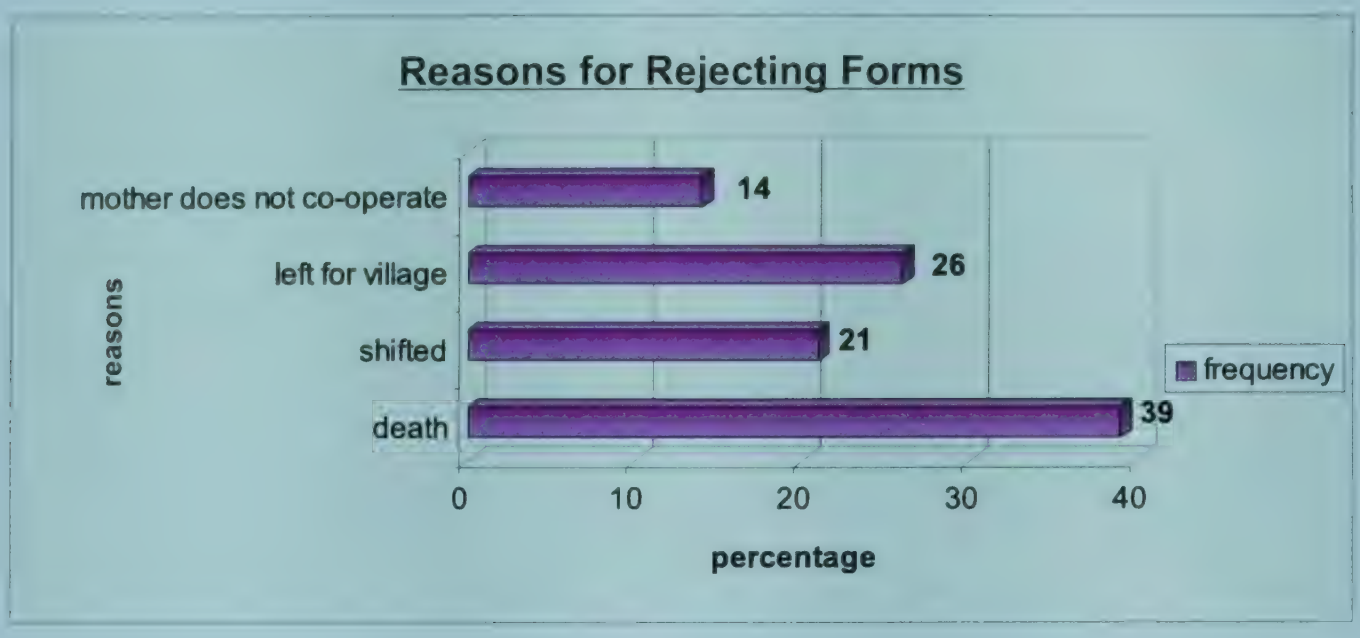
Though in the beginning the sample size consisted of 250 families, the sample size had to be increased for the following reasons:

49 families were adopted for the action research from a slum near Dakshinpuri, so that the information collected is not restricted to a particular condition and rather is generalized.

It was also noticed that frequent migration could be a inhibiting factor, as most of the families selected were living on rent, chances were the sample size may fluctuate and the numbers might reduce, hence more families were included in the study and sample size grew from 250 to 270.

Thus the over all sample grew from 250 to 319. In the following years it was found that 20% of the families, could not continue with the study as 6% of the children perished, due to various reasons and 14% of the families either migrated back to their village or shifted from the selected area.

Depending on the presence or absence of families, the domain(denominator) for different findings was always fluctuant.



(Figure 1)

2. IV. Analysis

The research was action oriented, which included data collection and simultaneous interventions to fill in the gaps or loopholes encountered. The data was collected from the forms administered at different time intervals of child's life.

Information/ data collected could be divided in various rounds:

Baseline: the 1st two forms based on the background information which included questions on the family size i.e., number of children and adults in the family, economic status, sources of income, education level, age at marriage, child care practices, etc. to name a few. These forms provided us a foundation to work on by elaborating the existing situation.

1st round of survey included administration of the forms from pregnancy to 18 months of age of the children. The information was collected after daily visits to the household and families/ mothers were given suggestions to take care of their children. To gauge the impact of our intervention, a comparison was made on the same indicators in the base line survey and the 1st round data.

2nd round survey: as the data collection was on the verge of completion, it was found that some of the women were pregnant again. This provided us an opportunity to gauge the degree of effectiveness of the interventions with a second round of reinforcement. Hence 33 households of the sample were again selected and the same series of form were administered. The data collected was compared to the information collected in previous rounds and the exercise depicted a steady change in some of the practices of the community.

3. COMMUNITY ADVOCACY, COMMUNICATION AND NETWORKING

3.1. Activities

This formed an integral part of the action research – feedback loop and also became an effective medium to build perspective.

During the process of analyzing the data, it was realized the picture of health and childcare conditions is quite grim, even though we were focusing only on an iota of the community. A comprehensive strategy was developed to reach the larger community and bring about a change after assessing the situation from the information collected from 1st Round Survey; hence various media (IEC/ attitude building media) were planned and conducted at nodal points of the three blocks (A-1, A-2 and B-1). Along with this presentations on the data collected from action research were organized in the community, with the help of pie charts and other pictorial depictions of data. The community was asked to first predict the condition and then the data from the action research was shared with them. This served as an eye opener to many.

A public meeting in partnership with 2 other NGOs was organized. The objective of the meeting was to address the public grievances regarding basic facilities. 11 organizations and 114 community people attended the meeting. All the Government officials from PHC, CDPO and Delhi Jal Board were invited but did not attend the meeting. 21 individuals came forward to share their problems. These problems were then compiled into a report by the panel and were sent to the Government for consideration.

Community sensitization and group formation: five community meetings were conducted to share the data collected from the ongoing research and to evoke discussion on the prevalent health conditions in the community, through an interesting procedure: first, women were asked to comment on the situation and present it in terms of percentage or diagrams as they understand it. Thereafter, the data collected was presented and compared. The long-term objective of these meetings was to identify the women and form their community group, who could in future take up the issues of health and mobilize the community to procure improved facilities for children and adults alike. Through these meetings 100 women, 35 men and 20 adolescent girls were reached.

A group of 15 women have been identified to form a community group to deal with the problems faced by the community in the field of education.

"Sharing of action research data with community"

Community Awareness: The energy and efforts of the team was also directed towards making the larger community women aware of the Importance of Early Childhood Care and Development. A plan was developed to reach people in the area in a systematic manner.

The long term objective of the above awareness activities was to develop community groups that were sensitized to the needs of children, begin to relate to each other and engage in collective analysis and thinking which lead them to collective action.

Some of the communication material used for ECCD discussions in Madanpur Khadar

"Khilta Bachpan": 8 performances with an out reach to approximately 500 in A-2 Block. This is a media presentation through story, song, puppets, picture scroll on the importance of the first six years of life. The story centres a round two girls and the difference in their nurturing, which raises issues of the impact of early childcare practices on the development of personality and capacity.

"Neenv Charts": 8 presentations of the Neenv charts with an outreach to 300. Each chart carries a visual with a key message about Early Childhood and is used to provoke discussion and reinforce key ECCD concepts.

"Khilta Bachpan"

"Neenv Charts"

3. II. Other Support Activities for Involving the Community

During the situational analysis, it was found that education is an area where immediate interventions were required. Initially the process began with building linkages with local resources, especially with NGOs working in the field of education and locals institutes too. Though many children got enrolled in the local school, another challenge was to ensure their retention. A scholarship programme for the children in the three blocks selected for intervention with interest in education and in need of support was initiated so that they could either continue with their education or begin afresh.
Some of the initiatives undertaken by Mobile Creches were:

Scholarship Programme: During this period, 28 children received scholarships to pursue their studies further. Visits were paid to their households to collect their results and identify new children, in need for scholarship.

Education Group: a group of 28 children was formed. This club provides children a platform to share their ideas and experiences and also to engage in constructive activities. The children have named their group a 'Ekta' (unity).

4. IMPACT ON PUBLIC SERVICES

4.1. Impact on ICDS centres

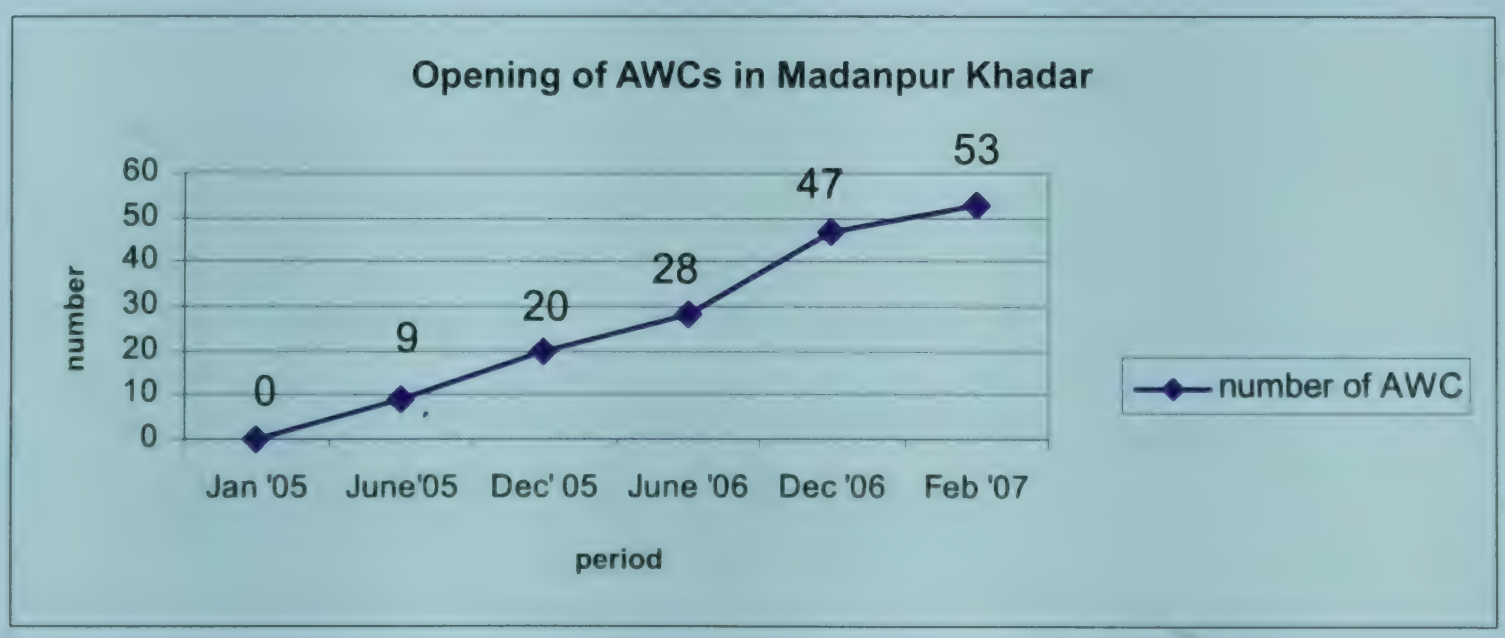
In 2000, when slums from different areas were resettled in MK, no health care services or ICDS centres catering to the needs of children were found. Simultaneously, a policy environment favouring the sanction of new ICDS centres for slums had been created as a result of the interim orders of the Supreme Court in the case related to food security schemes; (PUCL vs. Union of India and Others, Writ Petition (Civil) 196 of 2001).

After reviewing the situation with the Local NGOs and the AWW helpers who had relocated to the area and were jobless, the decisions to approach the government to open ICDS centres (aanganwadis) for the area was taken. Thus, a signature campaign and regular lobbying with the Government began.

After having mobilized women to demand aanganwadis we succeeded in having 53 ICDS centres opened in MK between 2005 and 2007 where none had previously existed. Efforts were made to strengthen relationships with the local aanganwadis.

A survey was also conducted, which provided us an overview on the situation of aanganwadis in Madanpur Khadar. The survey provided information about the existing problems faced by the workers, availability of food for the children, infrastructure, provision of health services and activities being carried out with children. The survey also helped in identifying the areas, which required further interventions.

The families associated with us have been sensitized to the importance of preschool education and have been motivated to send their children to aanganwadis. As a result, 60 children have been registered in their neighbouring centres.



(Figure 2)

4. II. Impact on Public Health Services

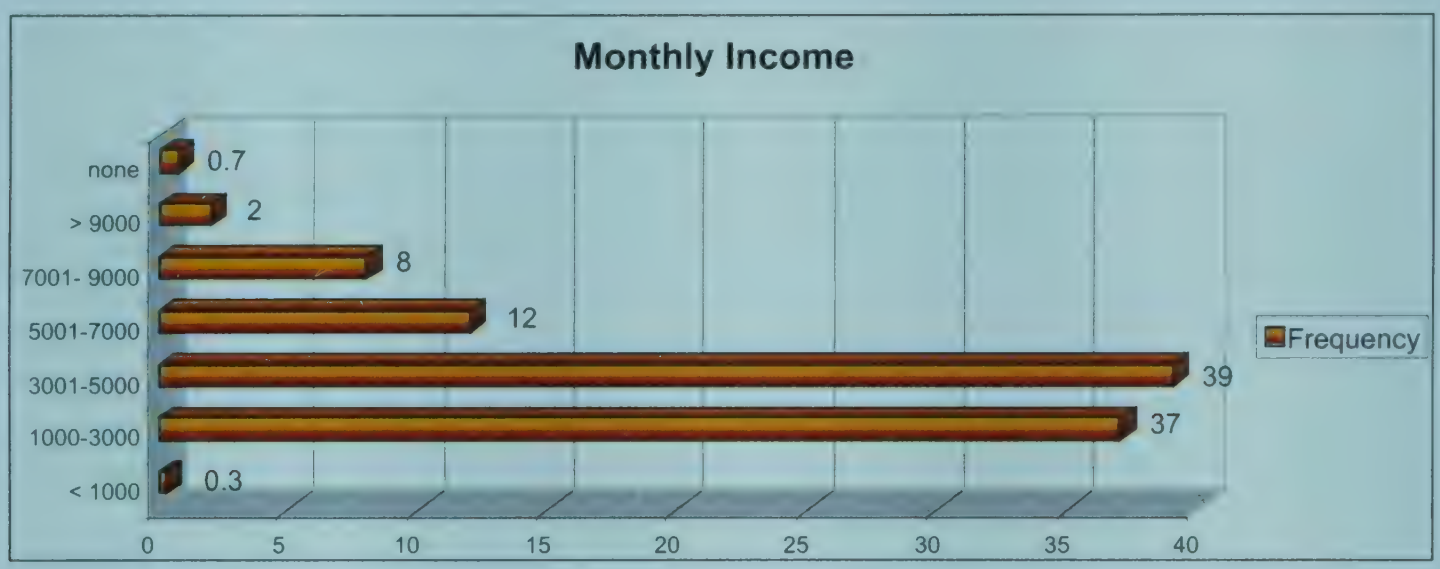
As mentioned, MK does not have a health centre and depends entirely upon the mercies of the PHC belonging to MK village which itself is poorly staffed to handle the extra patient load and is about 3 kms from the resettlement colony. Two small locked buildings did exist in the name of health centres. However, our best efforts so far, including a petition under the Right to Information Act did not clarified the status of ownership and responsibility over these structures. Pressure for better services however did result in the allocation of an ANM in April 2006 who attends the area on a monthly basis for immunization and ANC. There has been a marked improvement in coverage of immunization this is evident in the findings. (See below- Fig. 34). There have also been assurances from the government that a health centre would soon be constructed. However, this depends upon allocation of land by the DDA.

5. FINDINGS OF THE ACTION RESEARCH

5.I. Pre - Intervention

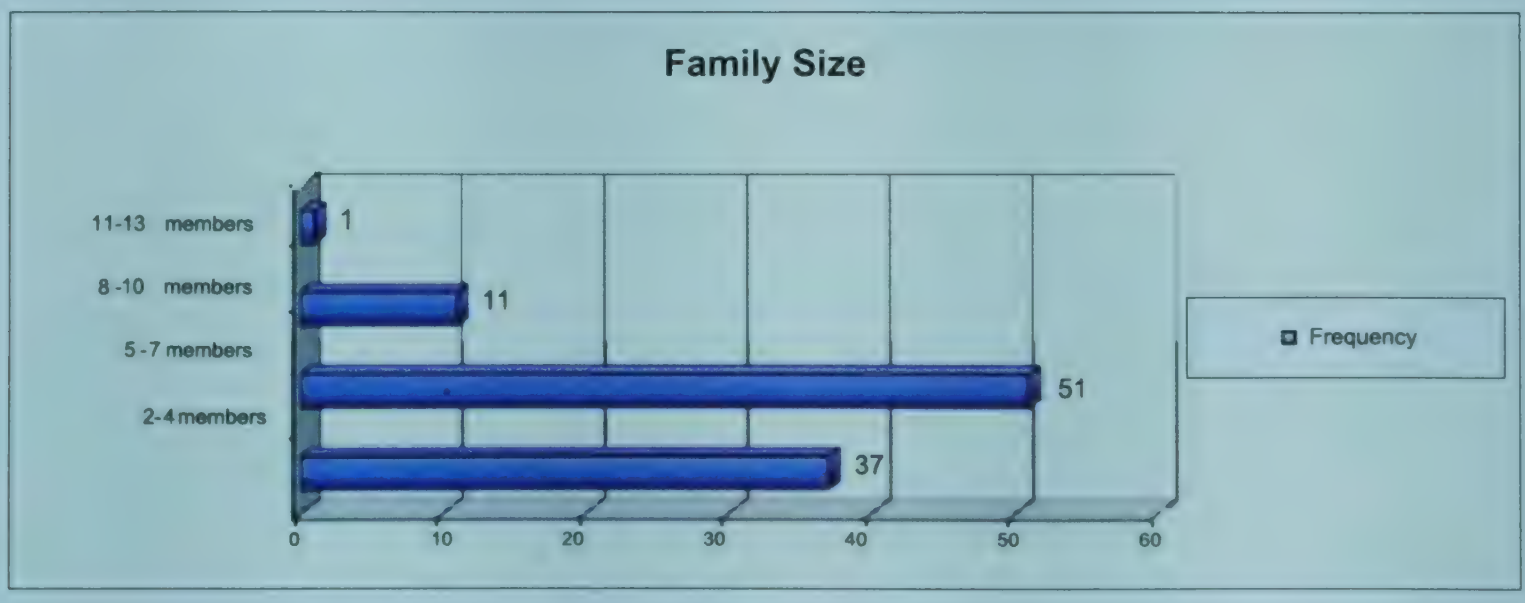
5. I.a. Background Information

Economic status of the family forms the crux of all the problems faced by them. The investment in health and childcare services also depends upon it. During the study it was found that majority of the sampled families earn between Rs. 1000/- to Rs. 5000/-. There were also families, which earn less that Rs. 1000/- per month due to unavailability of regular employment (daily wagers).

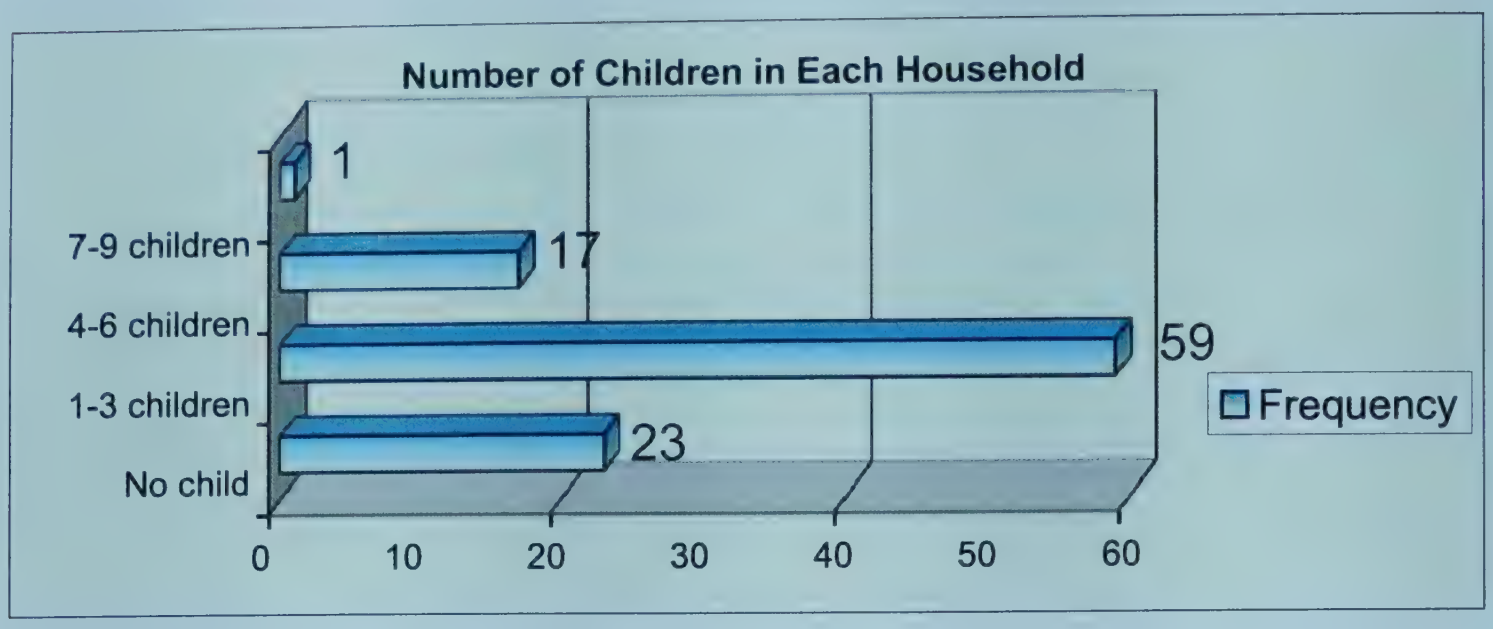


(Figure 3)

As the graph represents, most of the families covered had 5-7 members. Most of the Families had 3 children. However some had as many as seven.

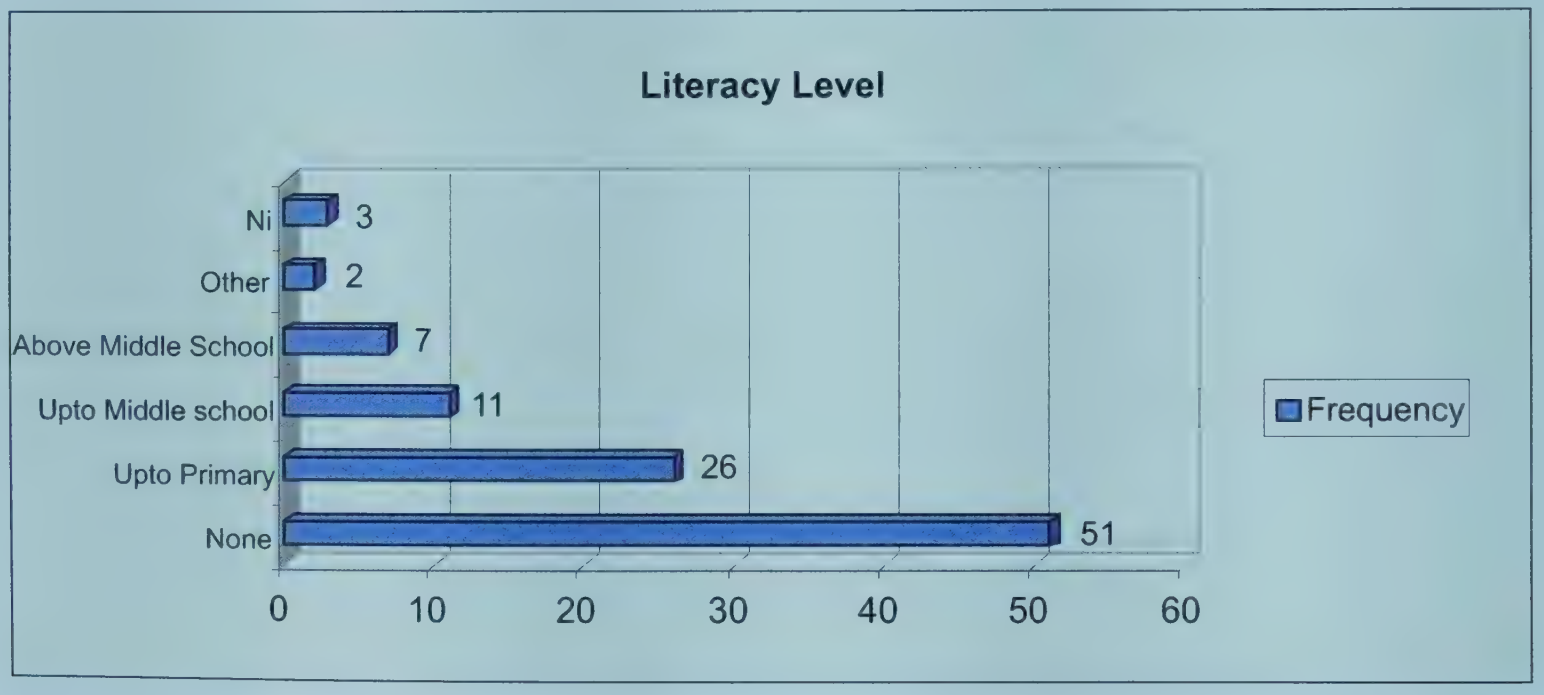


(Figure 4)



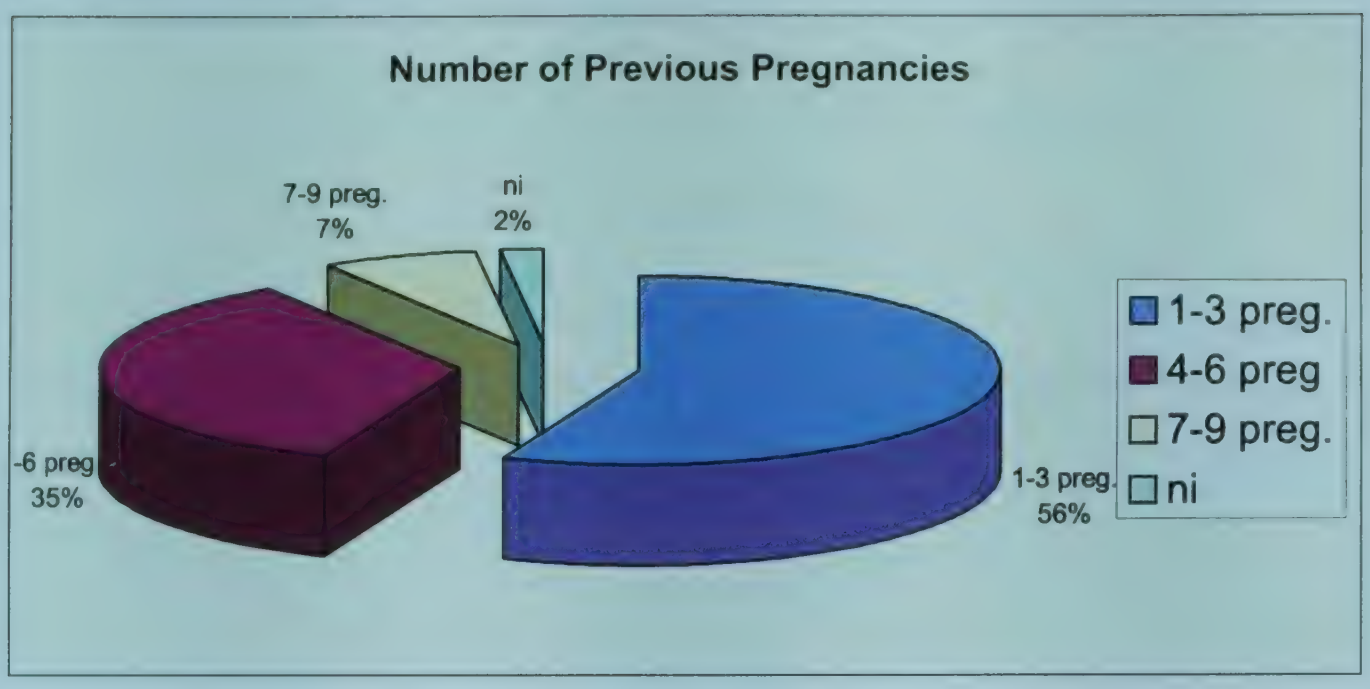
(Figure 5)

During the study it was found that 51% of the women had not attained any kind of formal school training while the rest of them had either done some schooling or had attained training in a vocational course like crèche management.

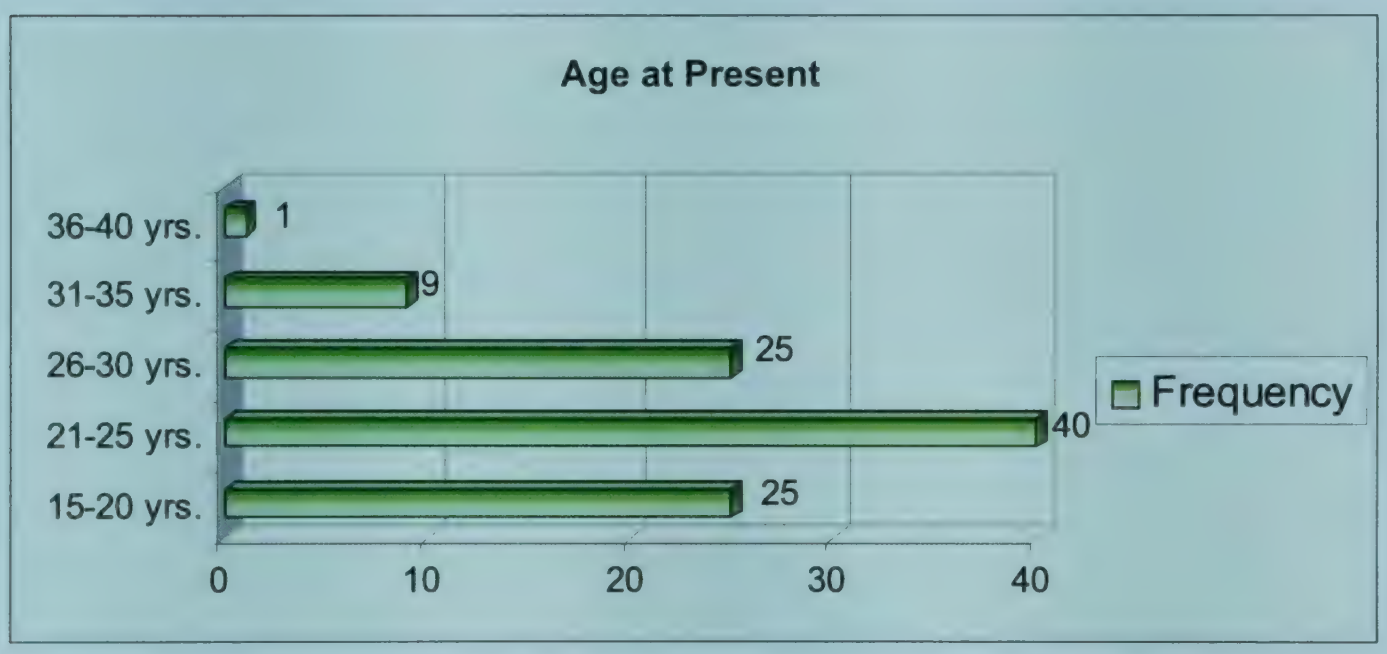


(Figure 6)

40% mothers were found to be young between the age group of 21-25 years. While a shocking, 25% of the mothers were below the age of 20 years, indicating child marriage and early pregnancy.

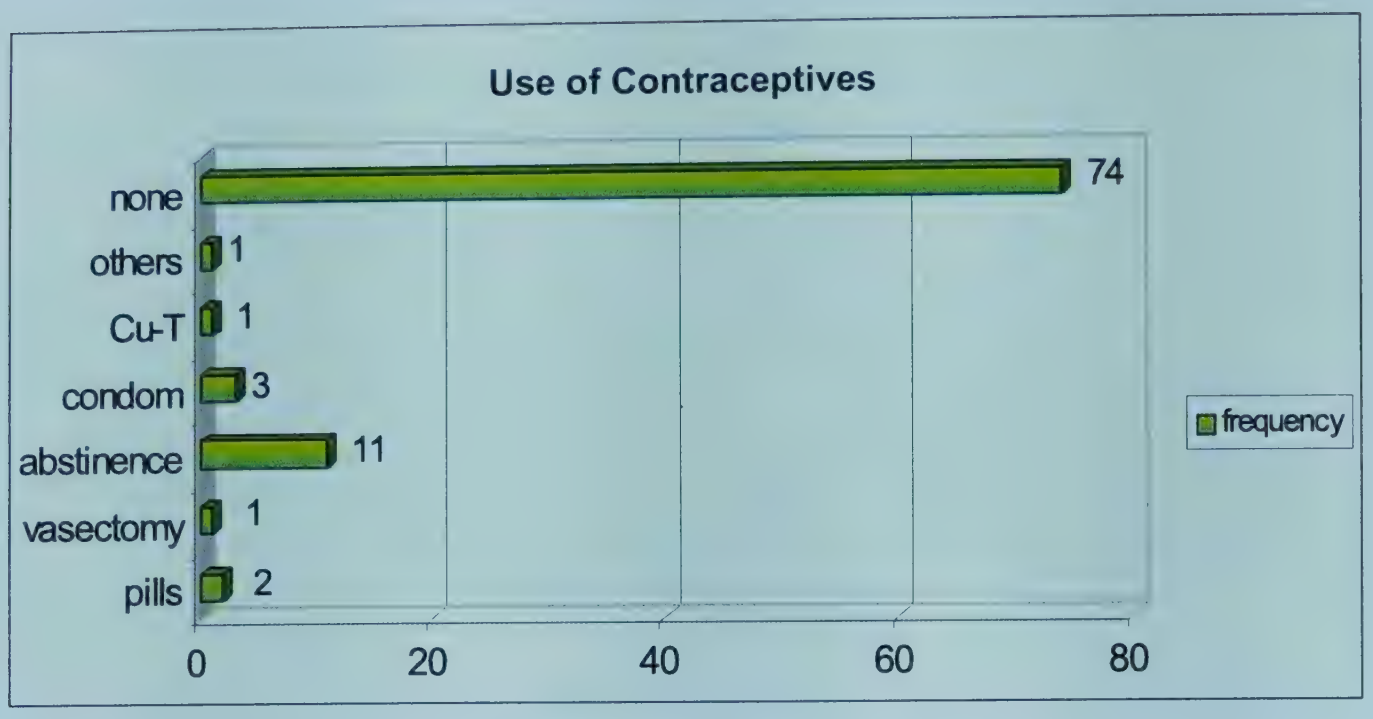


(Figure 7)



(Figure 8)

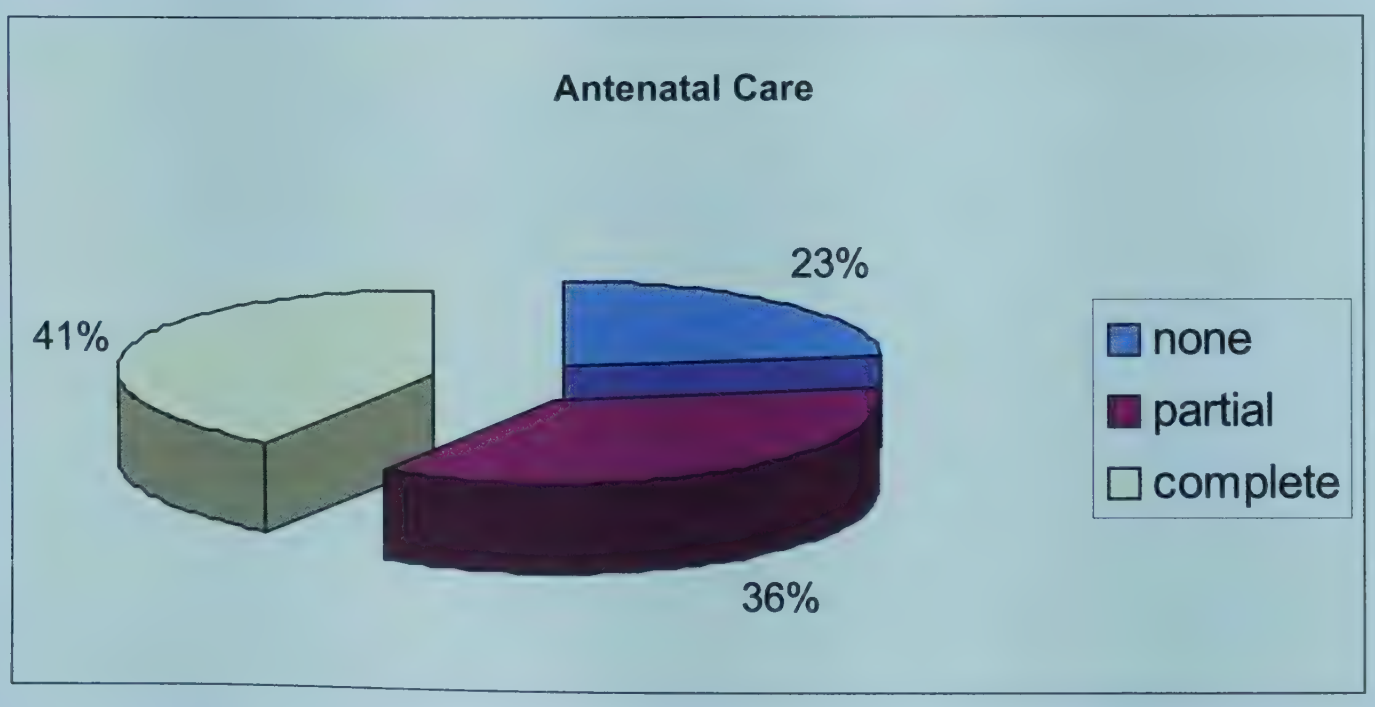
As is obvious, the use of contraception was low and women were found to go through many pregnancies at an early age. Subsequent discussions with the women revealed a high level of desire for contraception. However, they were deterred by the absence of services as well as the negative attitude of their husbands.



(Figure 9)

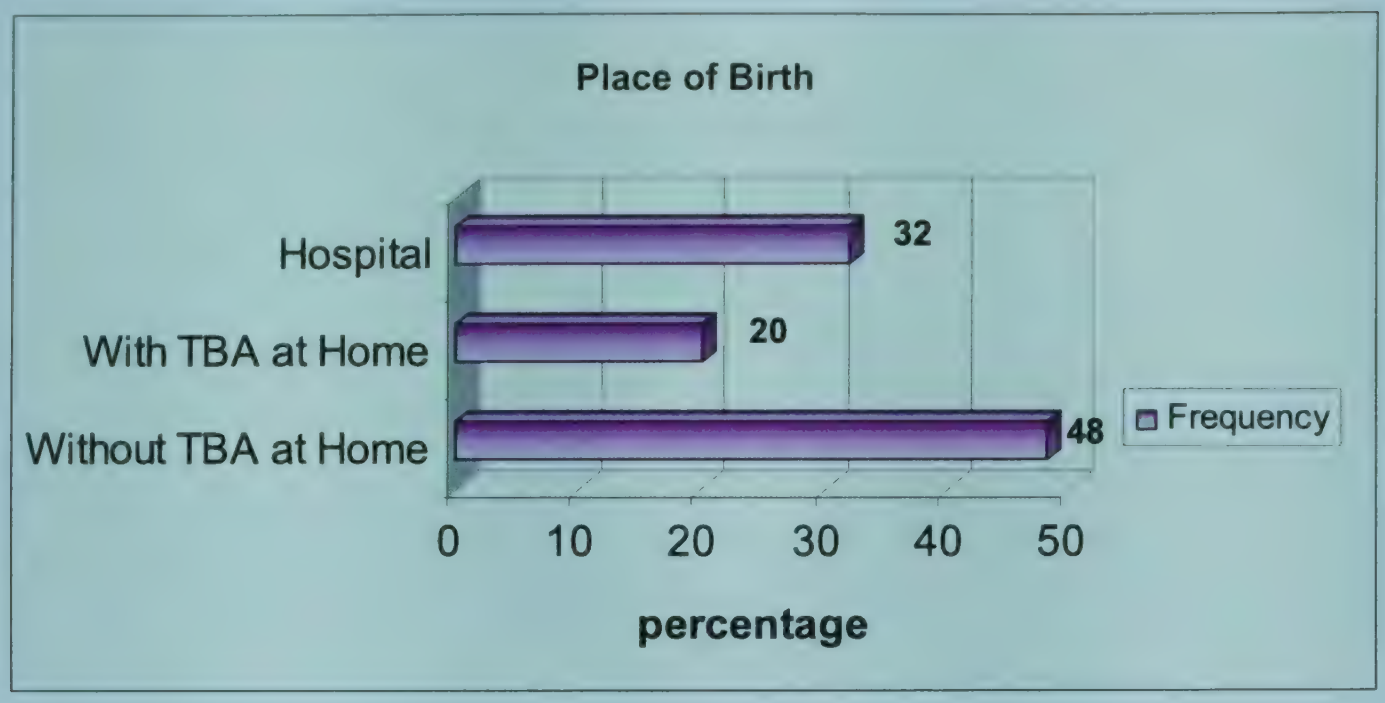
5. I.b. Baseline Data

Baseline information on practices during previous pregnancy and child birth Antenatal care during previous pregnancy 23% of women reported that they did not receive / avail of any antenatal care at all during the last pregnancy. The figure of those who received full antenatal care (41%) is possible inflated since it would be largely based on their own information of 'full', even though the facilitators were trained to elicit responses to the various elements of antenatal care.



(Figure 10)

Place Of Delivery For Previous Pregnancy



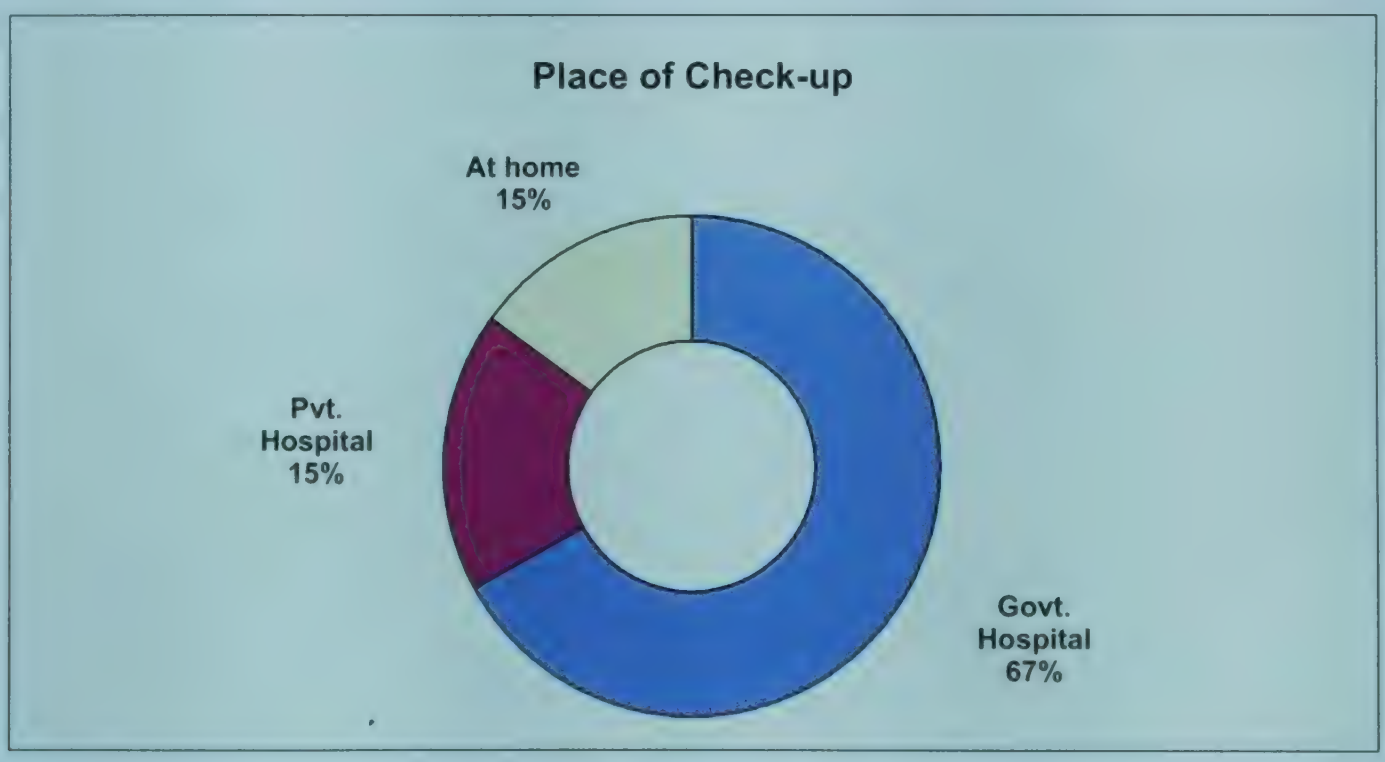
(Figure 11)

This was the baseline data collected before the intervention through the trained facilitators began during the current pregnancy or with the very young child.

5. II. Post intervention

5. II.a. Antenatal Care, Delivery, Prenatal Care, Neonatal Health

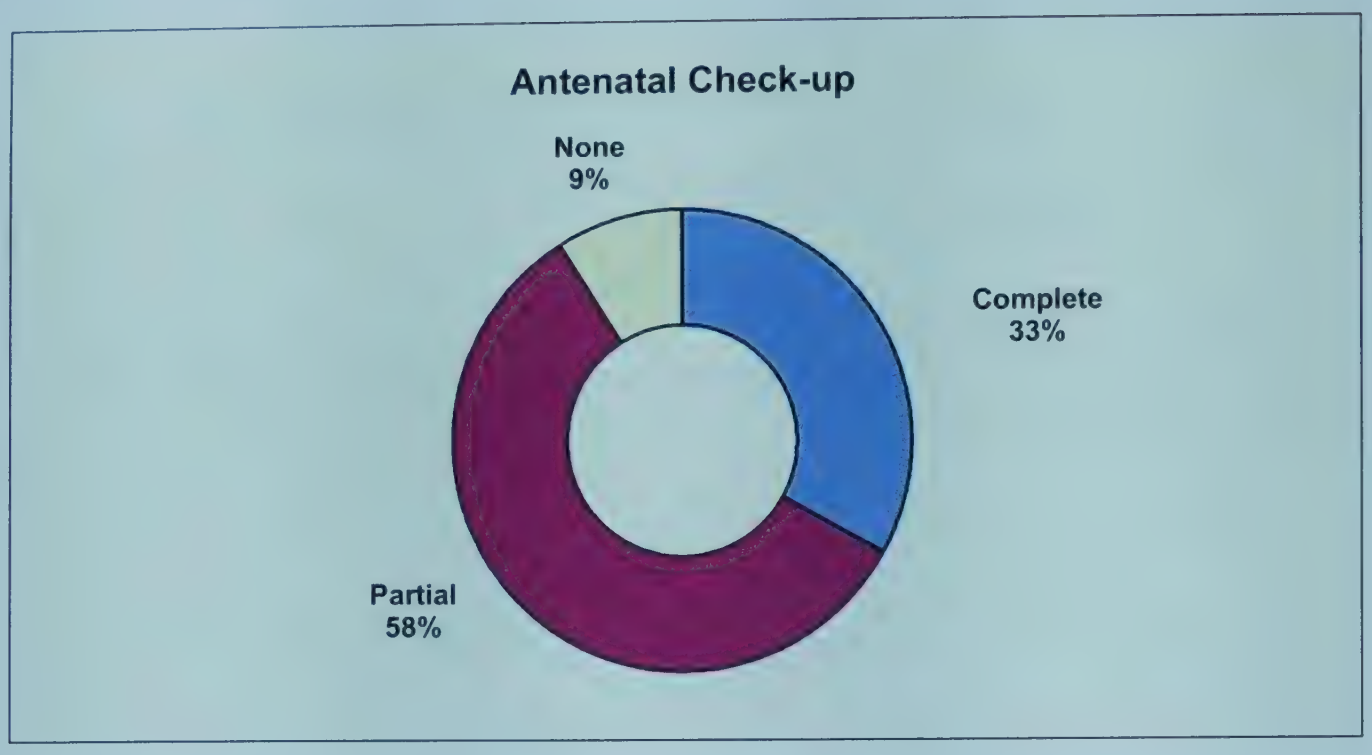
Place of check up



(Figure 12)

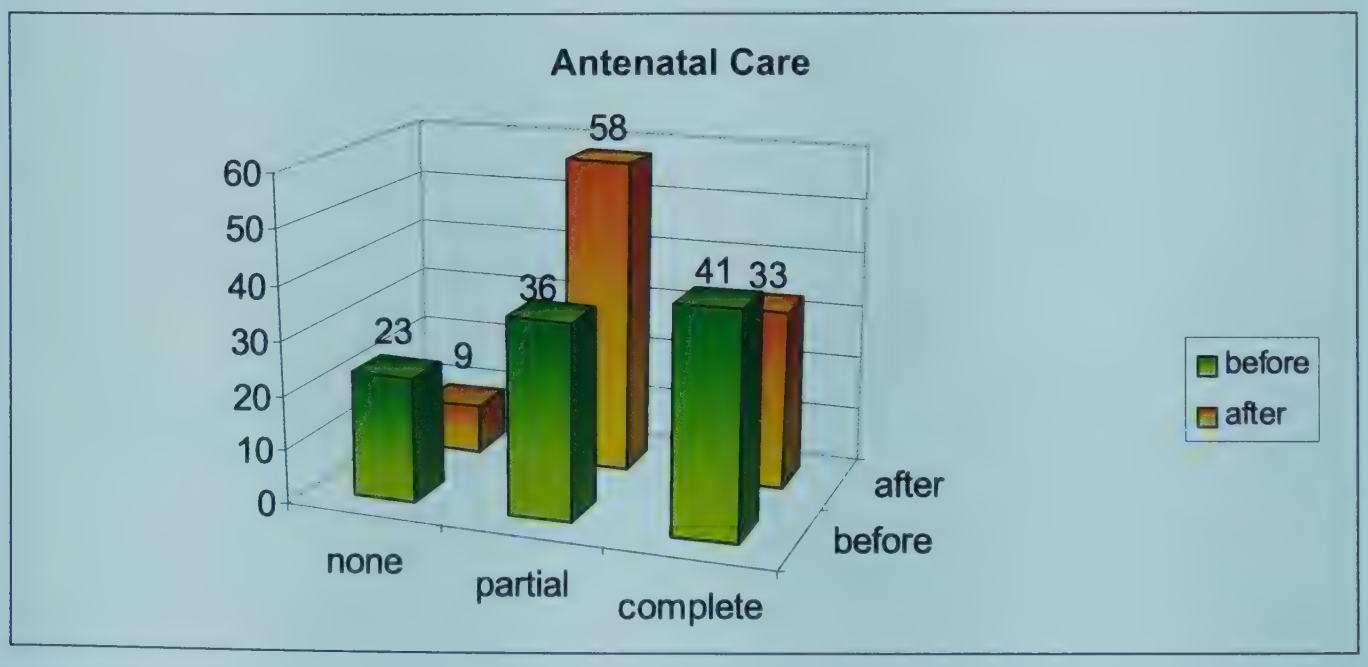
During the study it was found that majority of women had registered themselves for check-up at Government hospital, while 18% of them went to private hospital and 15% of the women didn't go anywhere for ANC.

Degree of ANC received



(Figure 13)

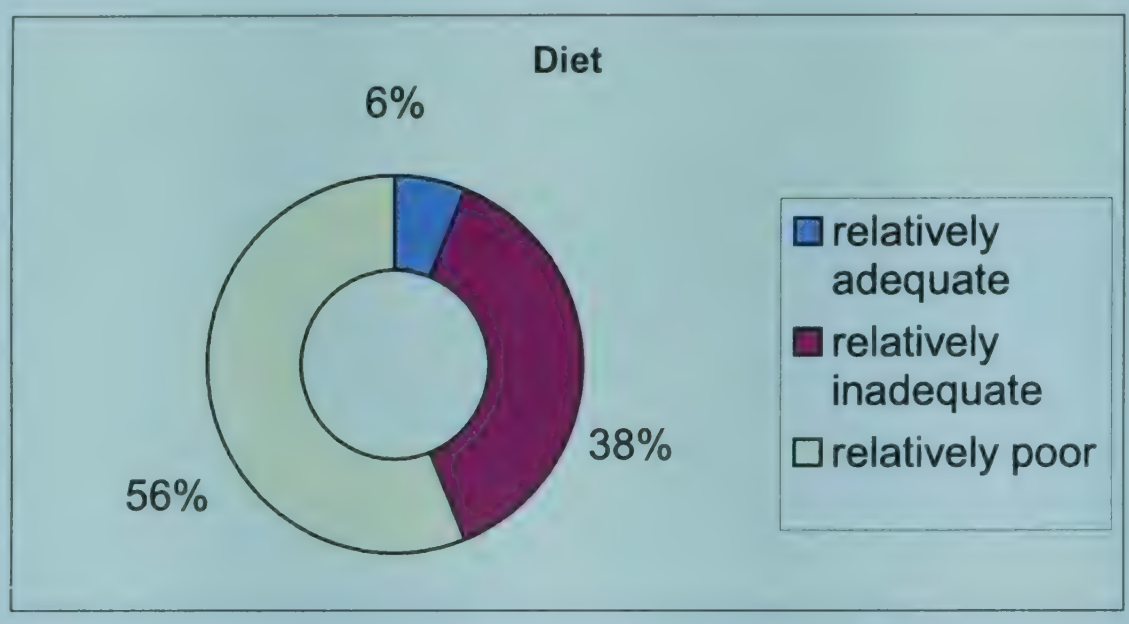
Nine percent women resisted ANC check ups completely despite motivation by the facilitators. This was an improvement from the baseline of 23%. The inconsistency between the 15% women not receiving ANC from anywhere (figure 13) and this figure may be because the facilitators were instructed to focus on the women who were not receiving care and the data in figure y was collected subsequently. Most of the 'partial' ANC was restricted to receiving tetanus injections and iron supplements.



(Figure 14)

On the whole, baseline figures of antenatal care showed improvement after intervention with only 9% women receiving no antenatal care as compared to 23% and 58% receiving partial care as compared to 36%. The slight decline in 'full' antenatal care is perhaps explained by the women's perception of 'full' while reporting the past, as explained above.

Diet



(Figure 15)

The assessment of adequacy of diet was based upon the facilitators / supervisors own judgment after training. Though descriptions of diet were required in the relevant form no attempt was made to quantify calories.

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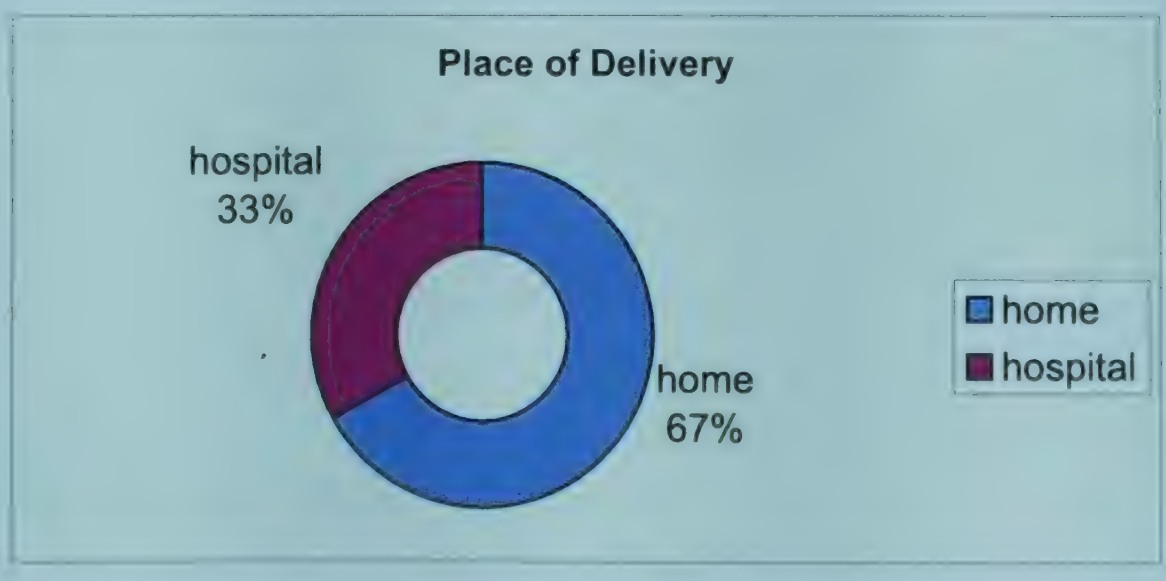
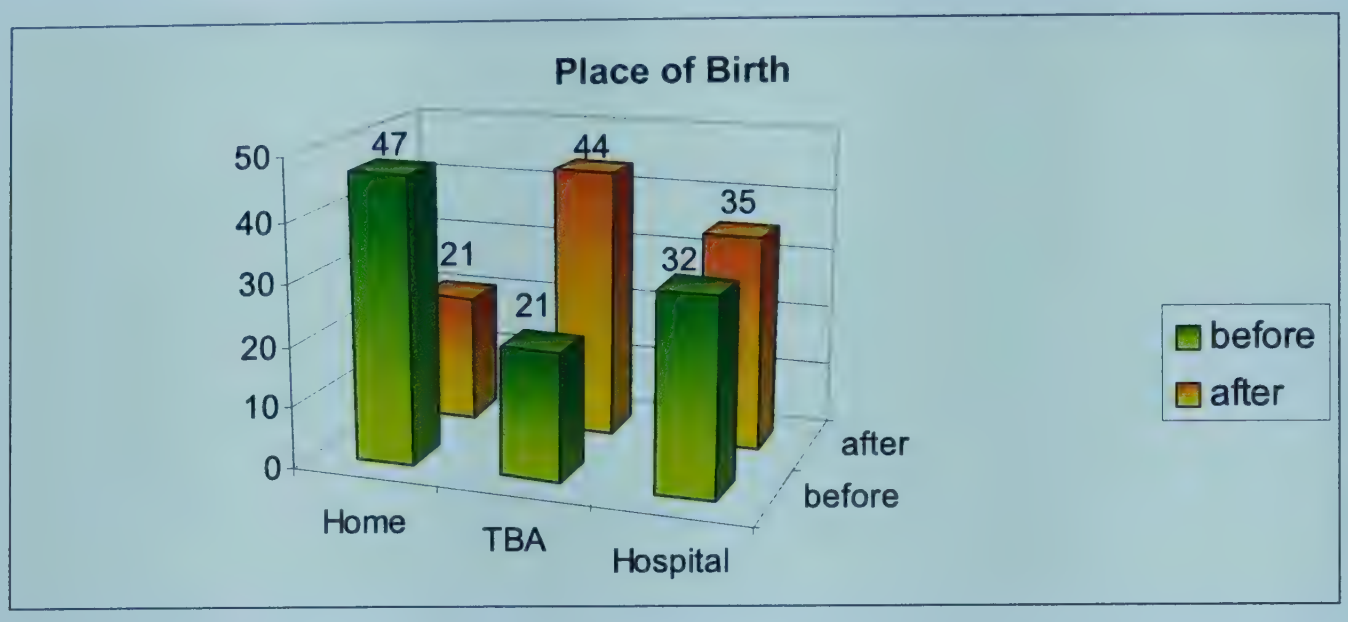
Place of delivery



(Figure 16)

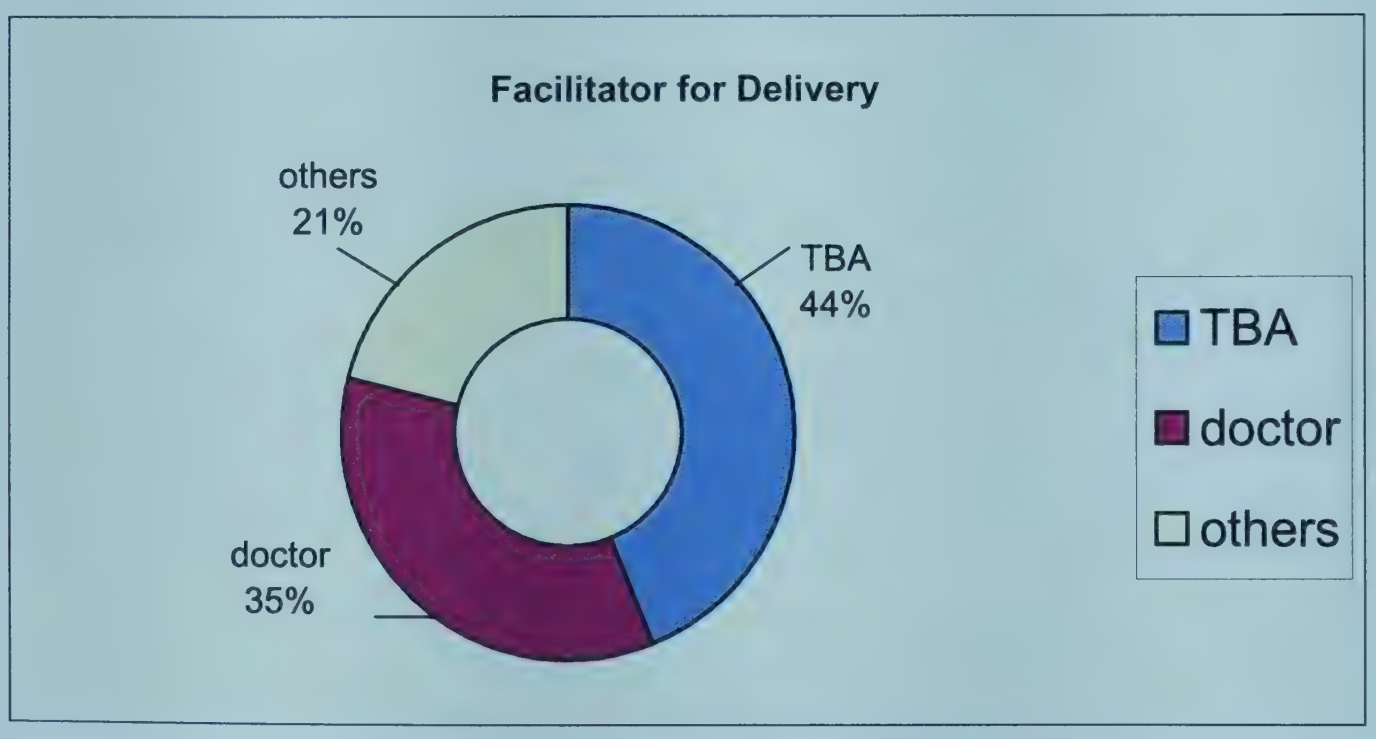
Two thirds of the women delivered at home despite the fact that many were registered for ANC at government facilities.



(Figure 17)

There was a significant decline in home deliveries without trained birth attendants and a slight increase in institutional deliveries.

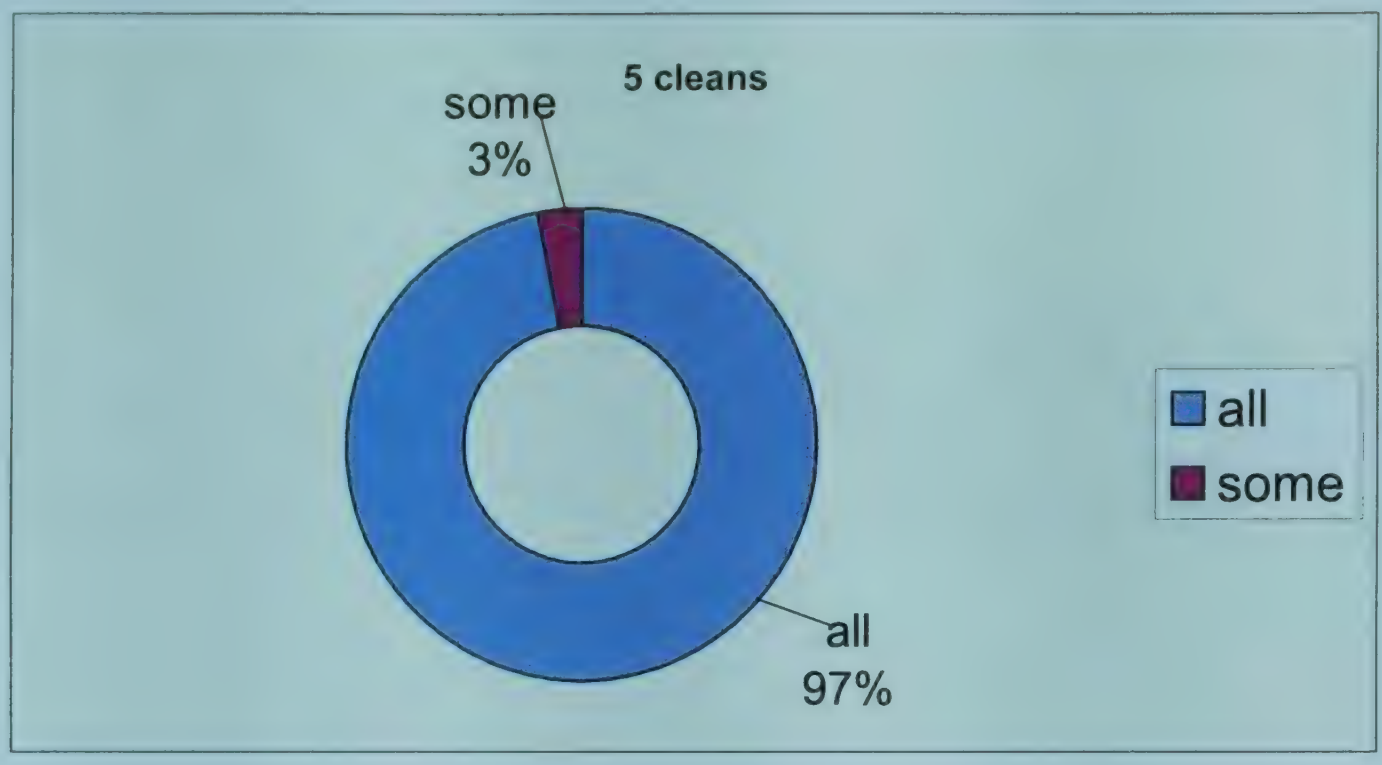
Birth Attendant



(Figure 18)

Though 33% women delivered at home, a slightly larger number reported having been delivered by a doctor. These small inconsistencies are usually the result of having different denominators for each set of data as families did constantly migrate in and out of the study.

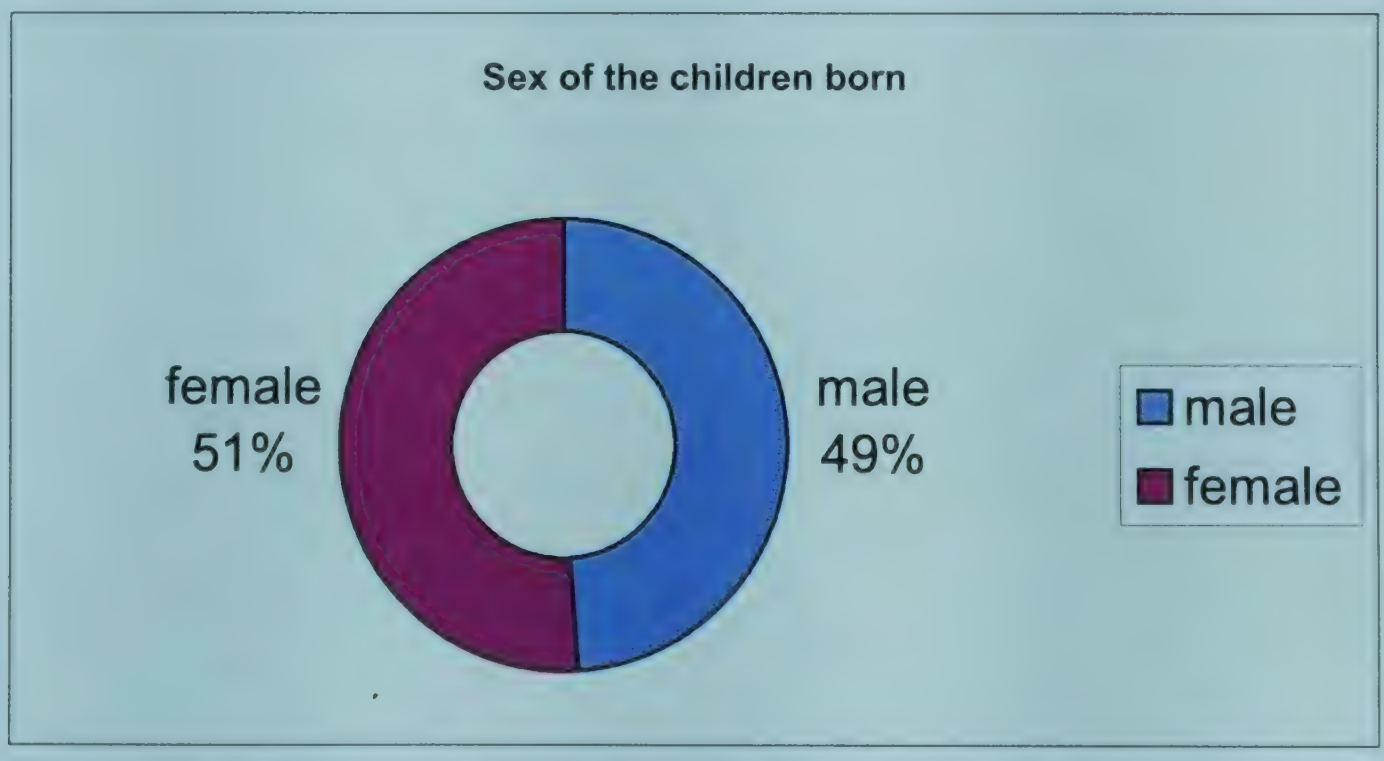
Safety of Delivery



(Figure 18)

Fortunately, a high percentage of deliveries observed the '5 cleans' and this reflects the good transmission of this information to traditional dais and the community at large. Facilitators had also reinforced this information during the antenatal period.

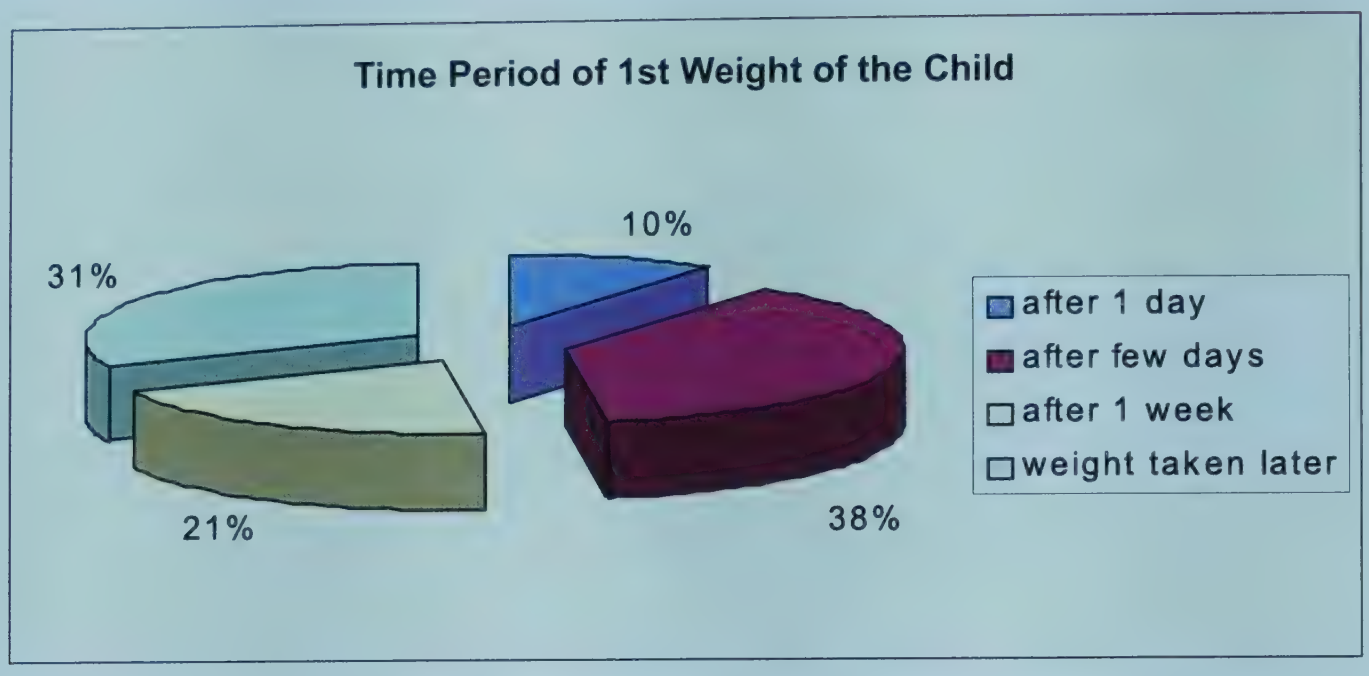
Sex of the Children Born



(Figure 19)

Interestingly, there was no gender difference and no evidence of sex selection.

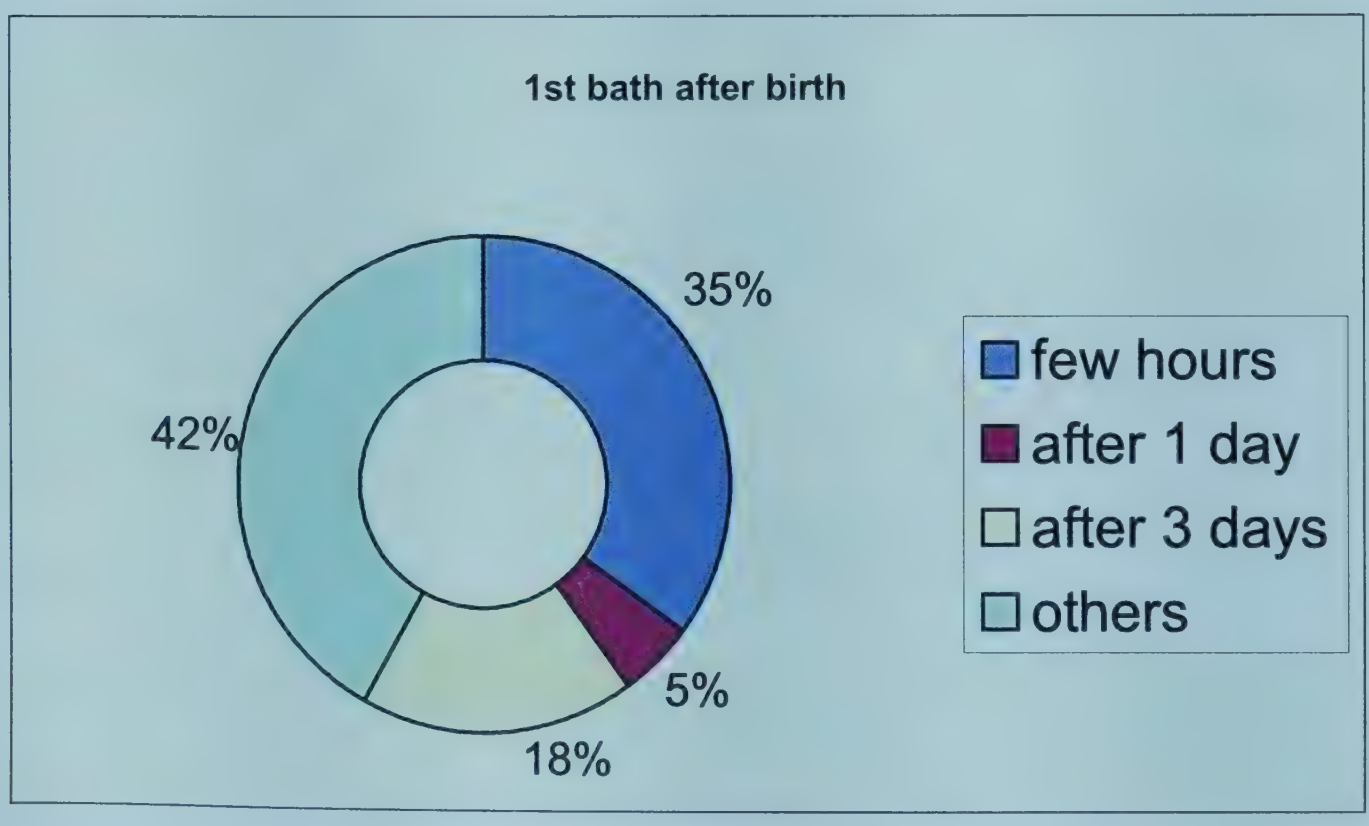
First Weight After Birth



(Figure 21)

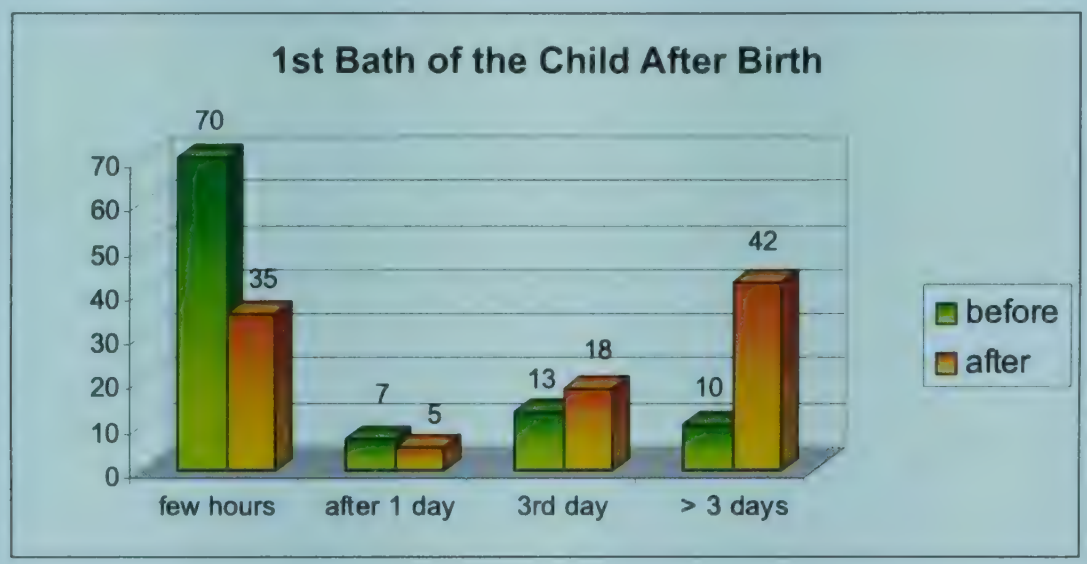
Though the facilitators were advised to take the weight of the baby as soon after birth as possible, this was a difficult exercise. Families had a hesitation in 'showing' the child to non family members till a traditional period of seclusion was over. Many families believed in the superstition that weighing would attract ill health or the 'evil eye'

First Bath After Birth



(Figure 22)

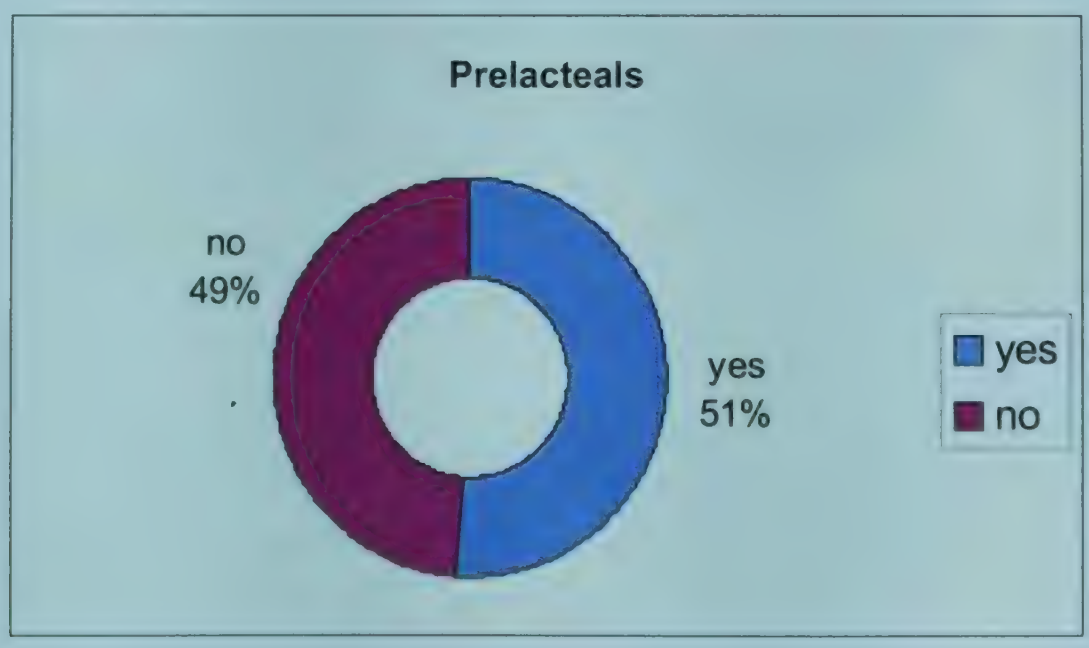
After the birth of the child, mothers are advised not to bathe them for a few days because they have a translucent cover on their body, which protects them from contracting any infection and getting cold. Traditionally, as soon as the child is born the birth attendants make sure to give him/ her a bath and then give them to mothers. Our efforts to change this practice met with limited success. Further searching revealed that a part of the dai's remuneration was linked to her having bathed the baby before leaving. Obviously, we would not be able to make a dent in the practice unless we could also change the 'contract' between the family and the dai. The fact that some families waited till the 3rd day to bathe babies was also linked to some traditional practices like waiting for a particular extended family member to arrive and perform the ritual 'first bath'.



(Figure 23)

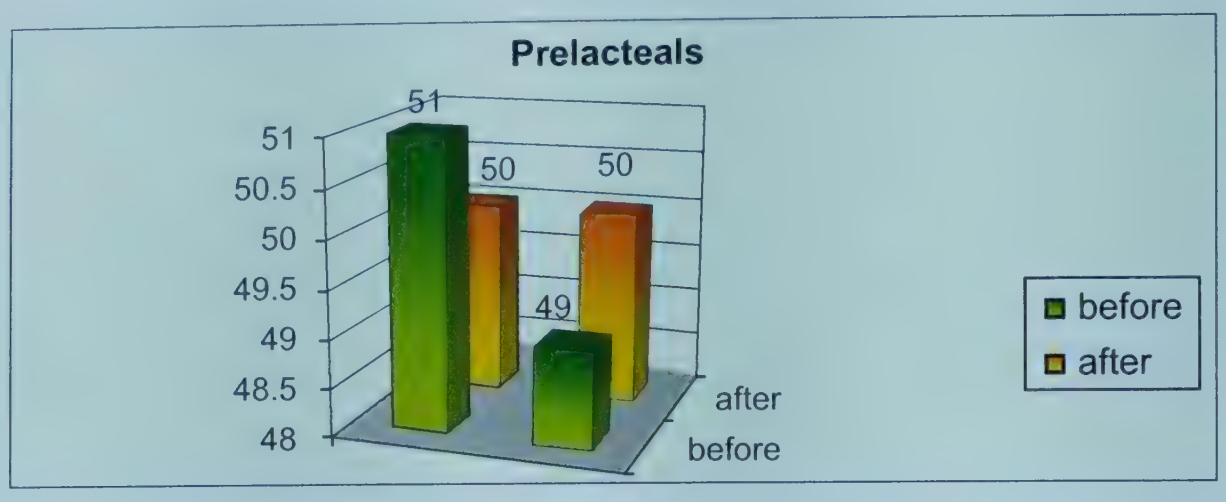
Nevertheless, there were distinct gains made as a result of the intervention as compared to the baseline and immediate bathing was reduced to half, from 70% to 35%.

Prelacteals



(Figure 24)

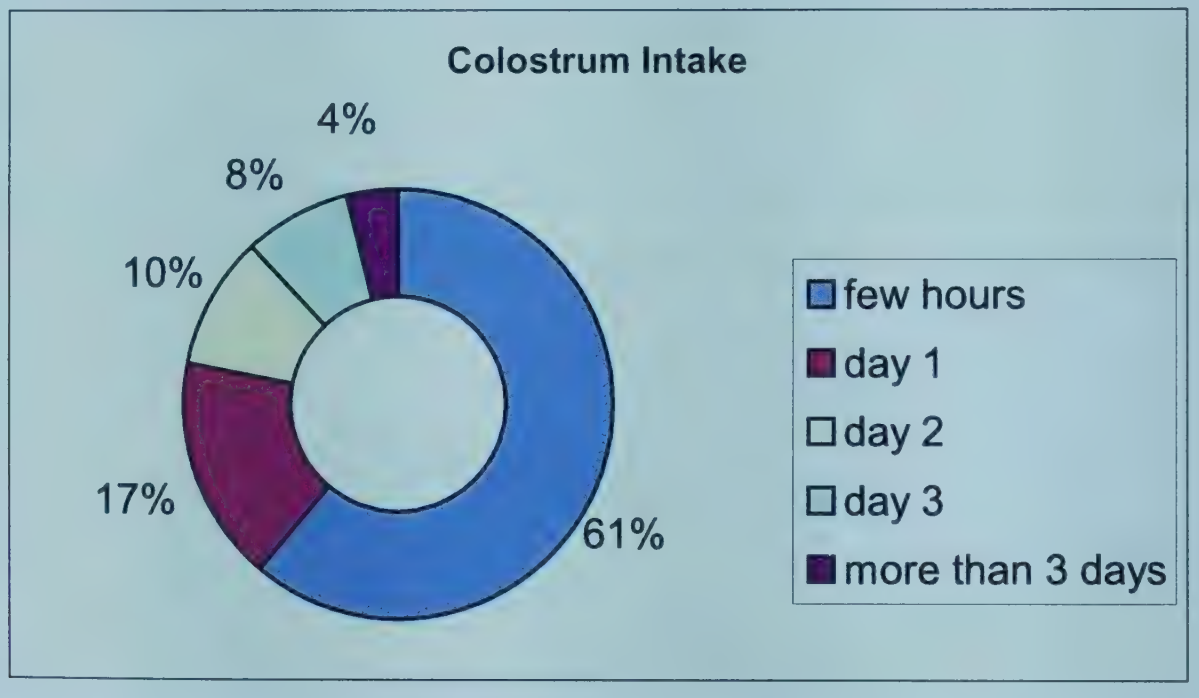
All pregnant women were to have received breast feeding counseling during late pregnancy. However, there was no distinct change from the baseline.



(Figure 25)

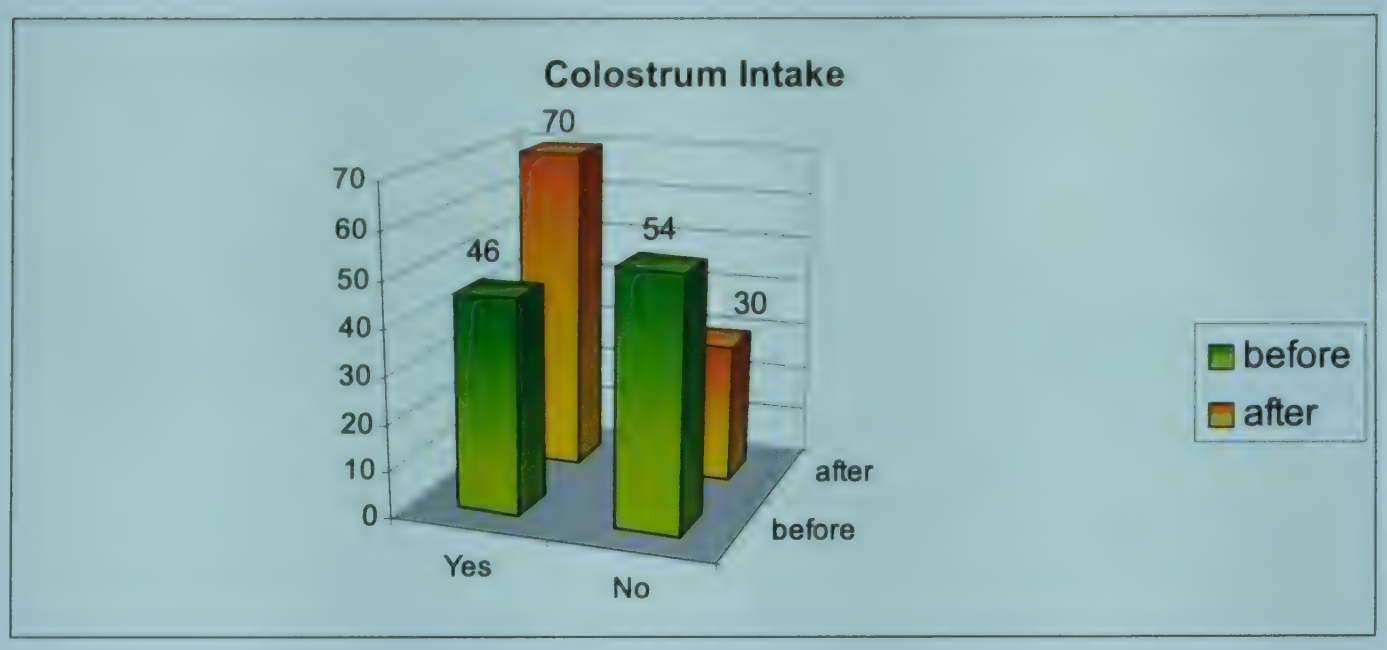
About half the babies born received prelacteals despite advice to the contrary and this figure showed no change as compared to the baseline. This shows the stranglehold of tradition and family pressure upon this particular practice and its particular intractability to breastfeeding counseling and education.

Colostrum Feeding and Early Initiation of Breastfeeding



(Figure 26)

70% babies were fed colostrum but at varying times. However, a large number of women initiated breast feeding within a few hours. A total of 78% started breastfeeding within the first day. It can be assumed that at least 25% babies must have received some other feeds since they received breast milk on the third day or later. This also loosely corresponds to the fact that about 50% received prelacteals.



(Figure 27)

There was a significant improvement in the percentages of babies who received colostrum, from 46% to 70%.

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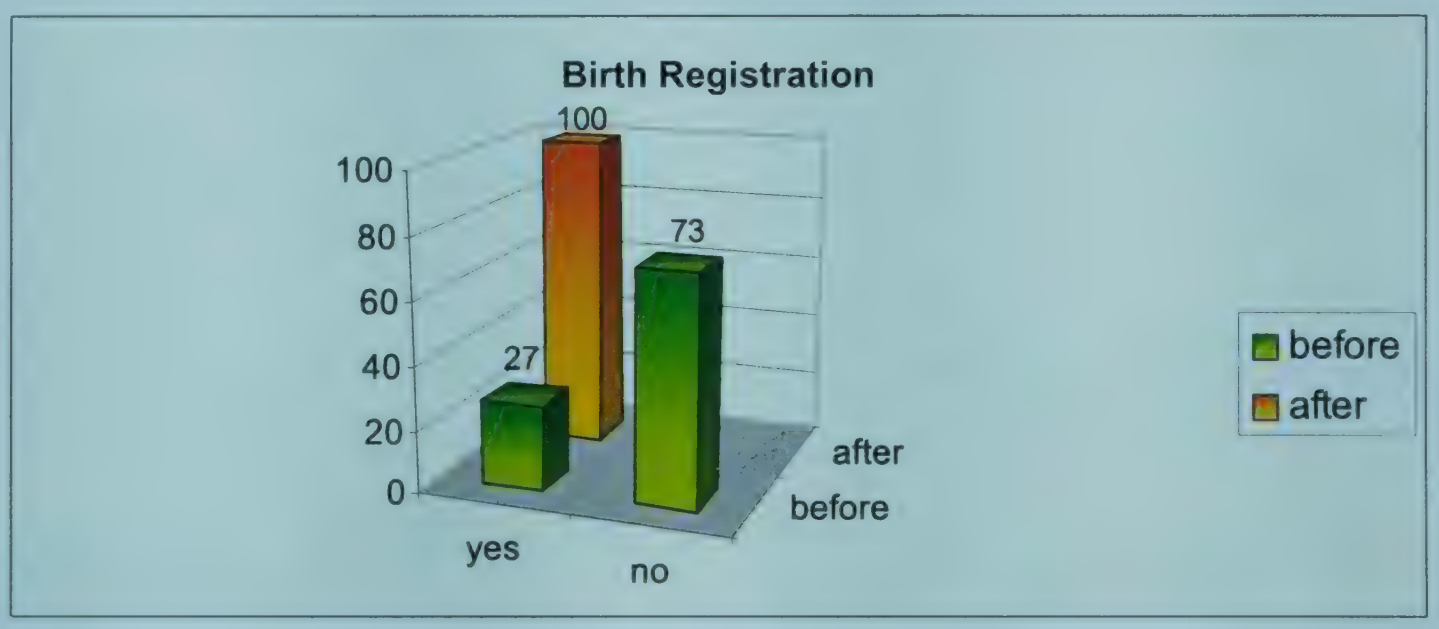
Birth Registration



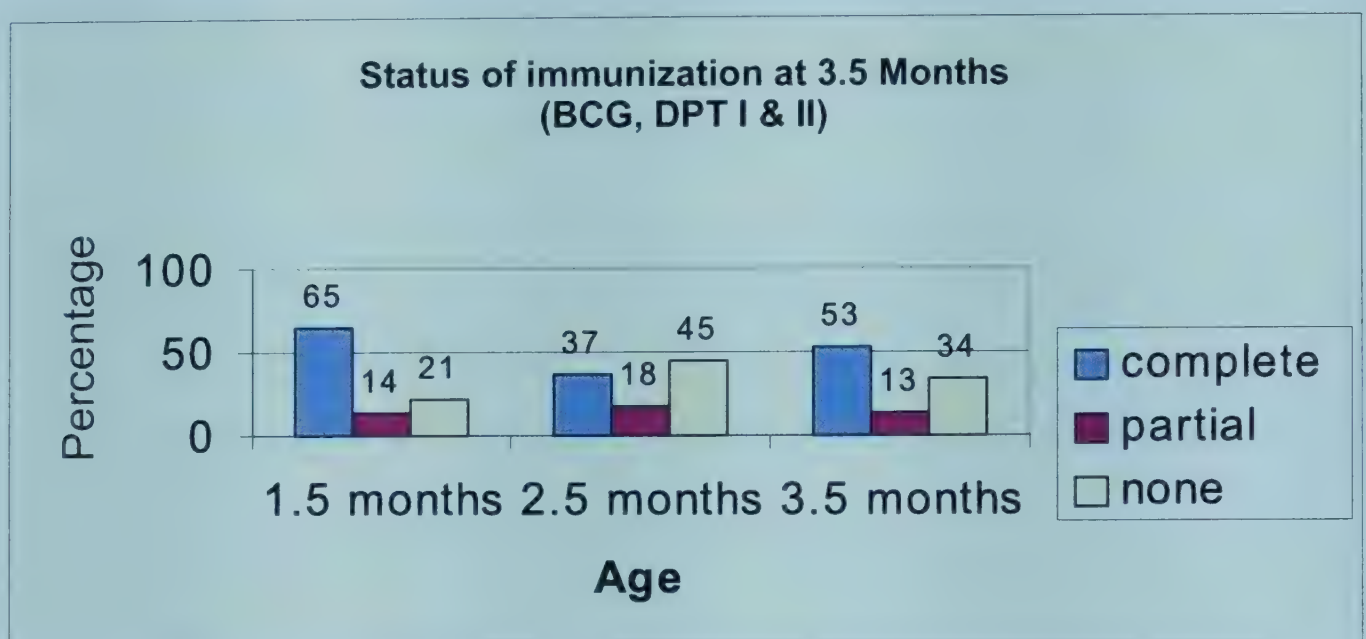
(Figure 28)

All babies were registered after birth as a result of facilitation by the team. However, there was a high level of 'direct' help provided for this action for the initial many months of the action research. Following this, a more participatory process was encouraged by which the community could get registration done without the direct involvement of a facilitator.

5. II.b. Immunization

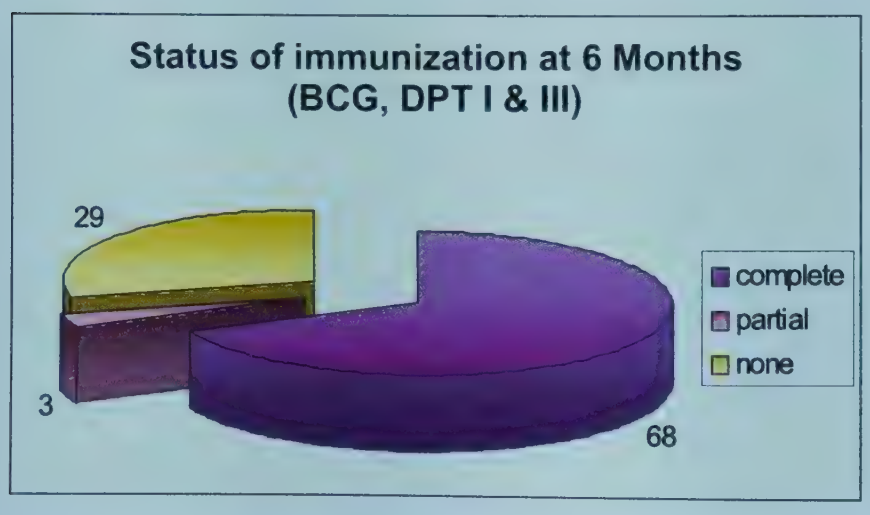
Immunization in the first two years comprises of many vaccinations and requires a lot of effort and motivation on the part of parents apart from information on the schedule itself. (We followed the schedule as per the Universal Immunization Programme).
Initially, immunization in MK took place through the rather distant and unfriendly MK village PHC. However, as described above, an ANM was posted to the resettlement area as a result of pressure in August'05 which resulted in a marked improvement.

In our two years of intervention, these are the patterns that emerged:

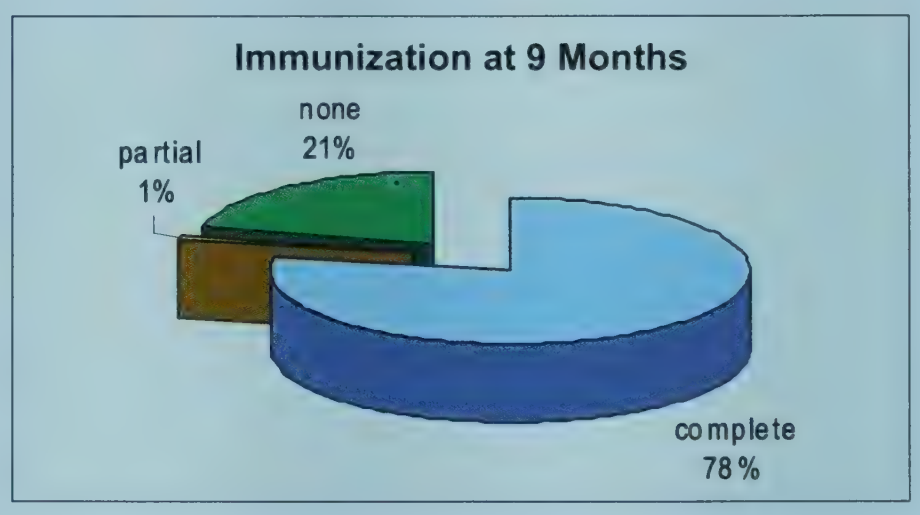


(Figure 29)

As other studies also show, coverage tends to deteriorate with age. This tendency was reverted following the analysis of DPT coverage through a renewed effort by the facilitators to motivate the parents.

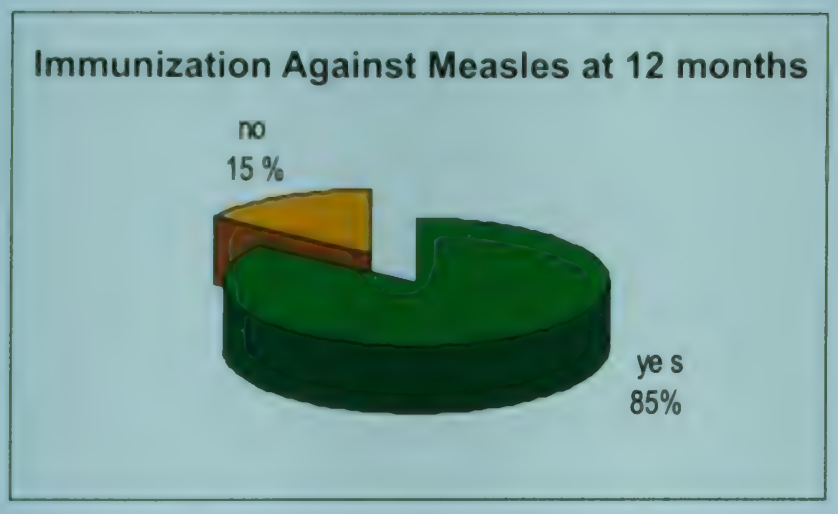


(Figure 30)

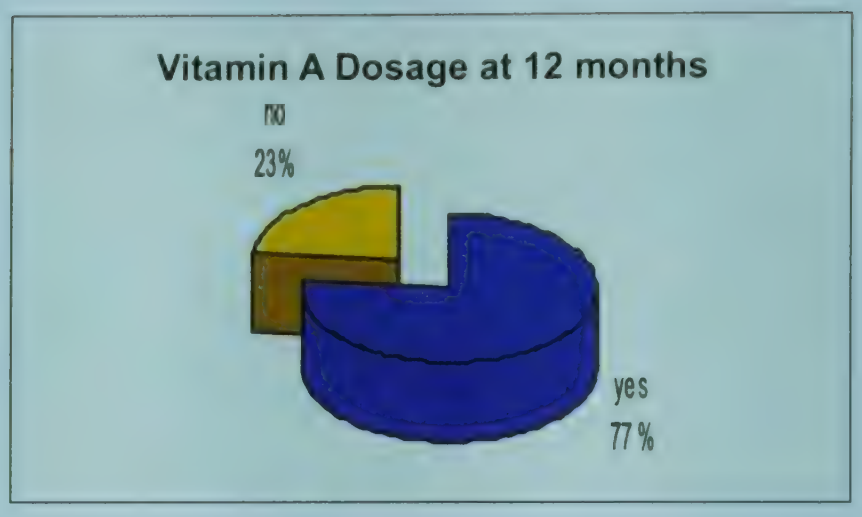


(Figure 31)

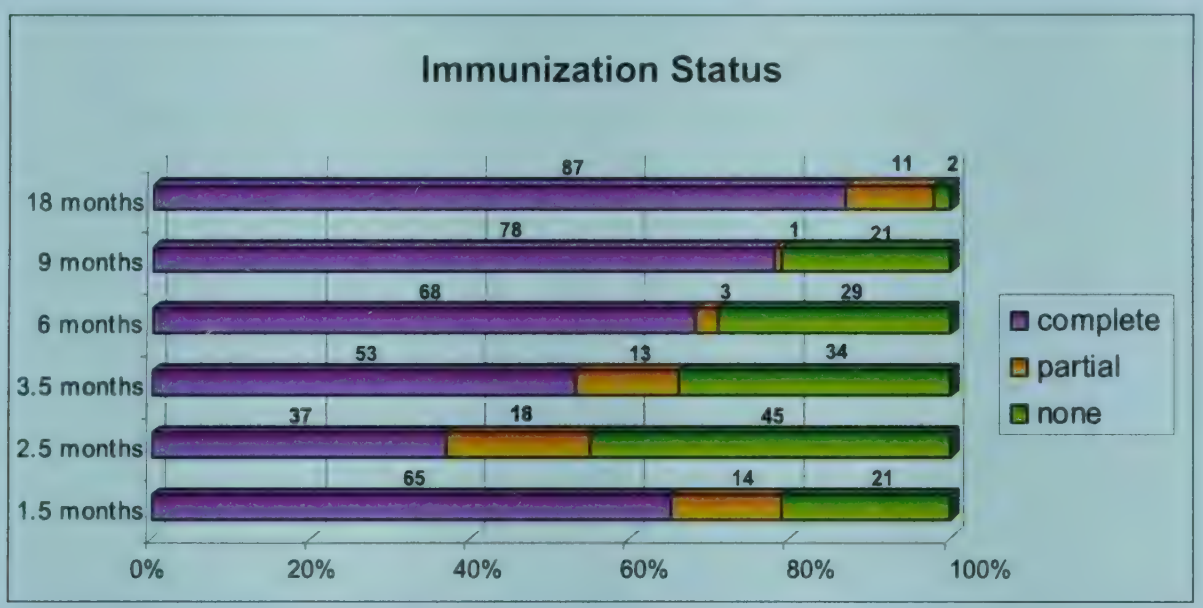
A senior nurse at the PHC was particularly rude and many women refused to go to the PHC on that account.



(Figure 32)



(Figure 33)



(Figure 34)

On the whole, after the initial decline after the BCG, there was a progressive improvement in coverage.

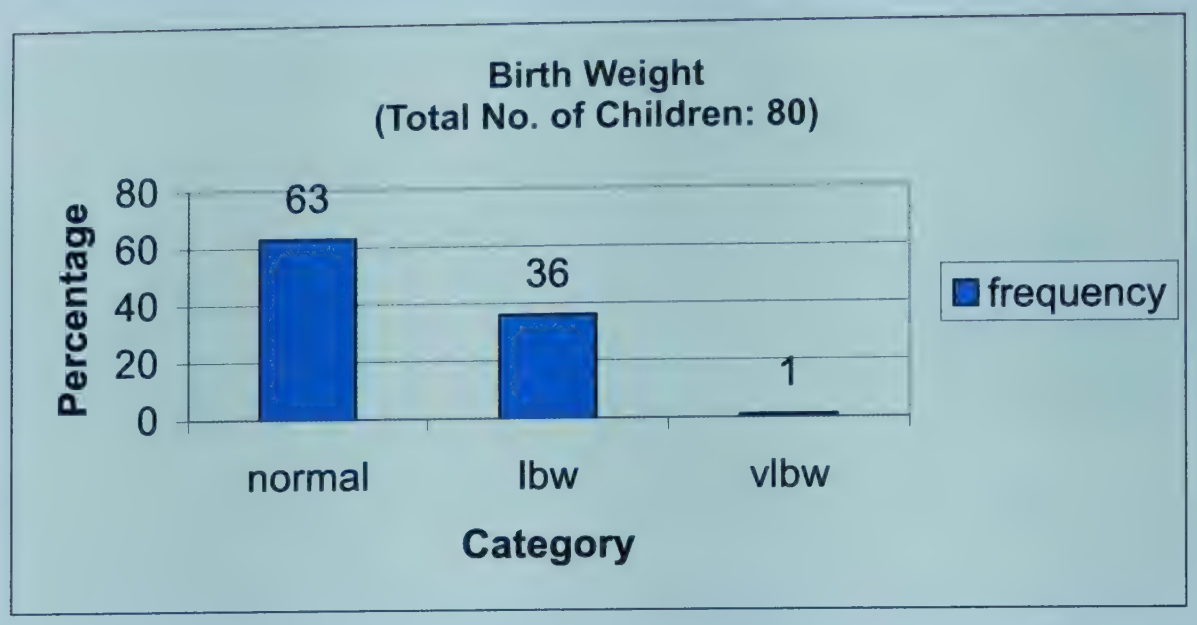
5. II.c. Nutrition and Malnutrition

Some feeding practices such as early initiation of breastfeeding, feeding of colostrum and the use of prelacteals have already been discussed.

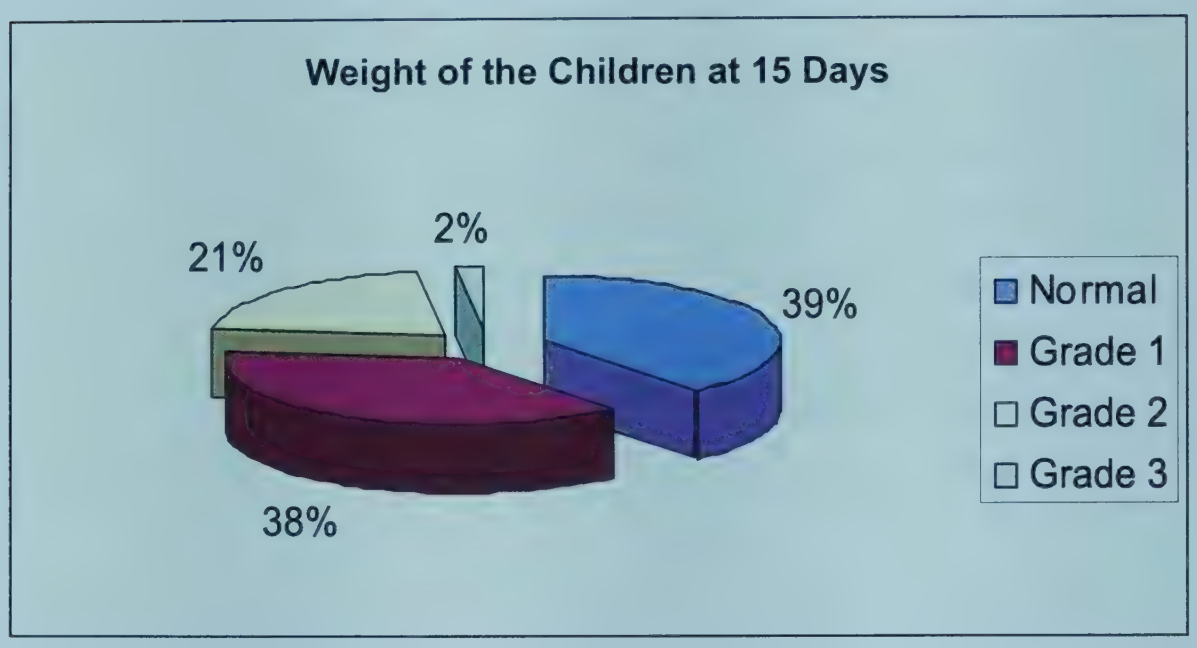
Other important findings were as follows:

Birth weight

As mentioned above, it proved to be difficult to weigh babies accurately at birth. Thus the birth weights of 80 infants born in hospital were analyzed as below:



(Figure 35)

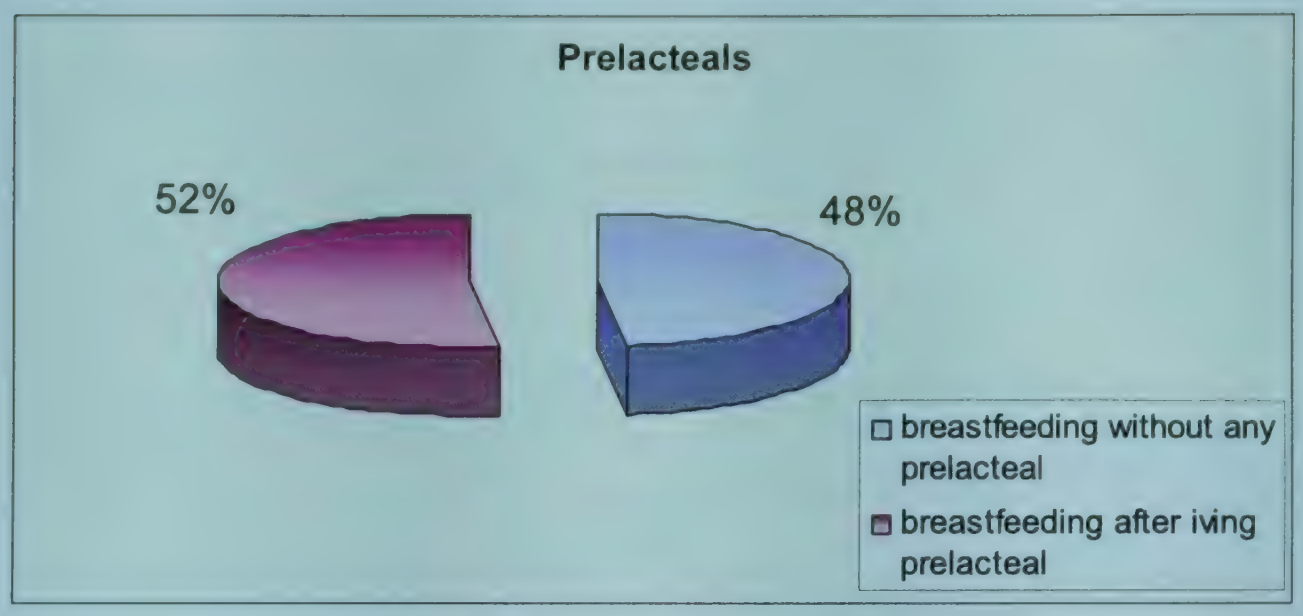


(Figure 36)

Exclusive Breastfeeding

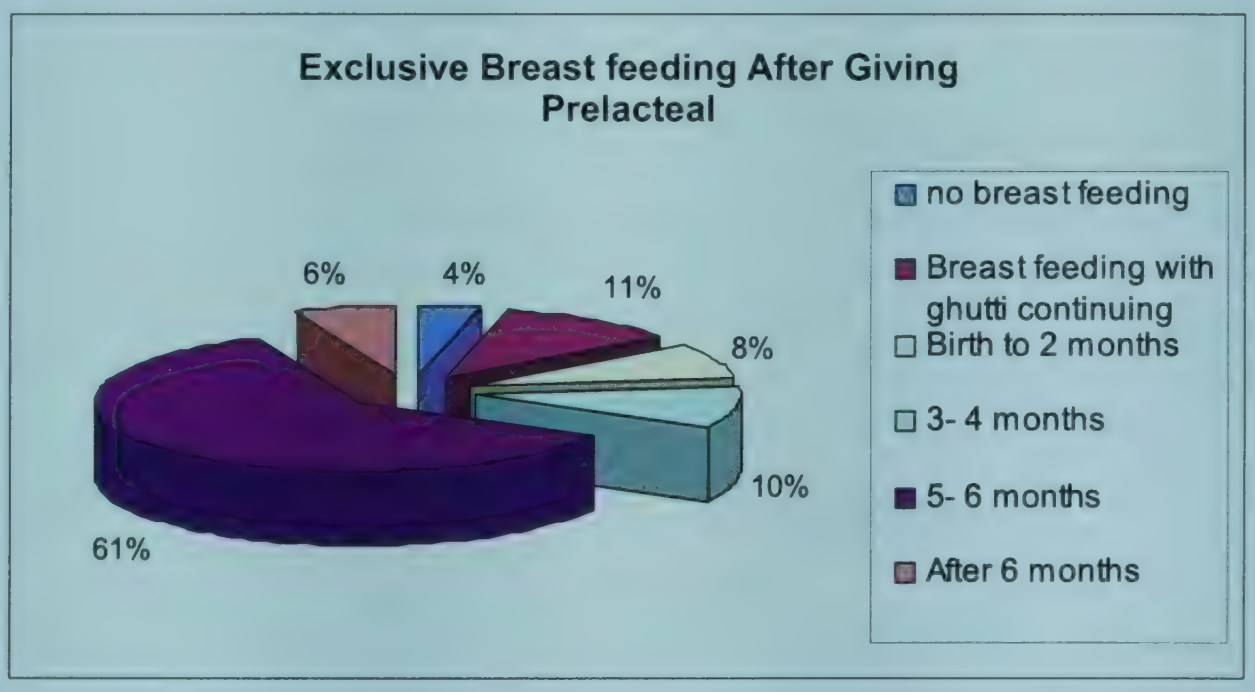
During the data collection on exclusive breast-feeding, the first attempt to collect data on the topic proved futile as the figures obtained were extremely high and were not coinciding with the data on prelacteals. Hence, an in-depth re-investigation was held to come to exact figures. The number of children reached during re investigation was only 196, reducing the sample size to half.

Out of the total, 94 children (48%) did not receive prelacteals while 102 children (52%) were given prelacteals. This corresponded neatly with the previously collected data on prelacteals.



(Figure 37)

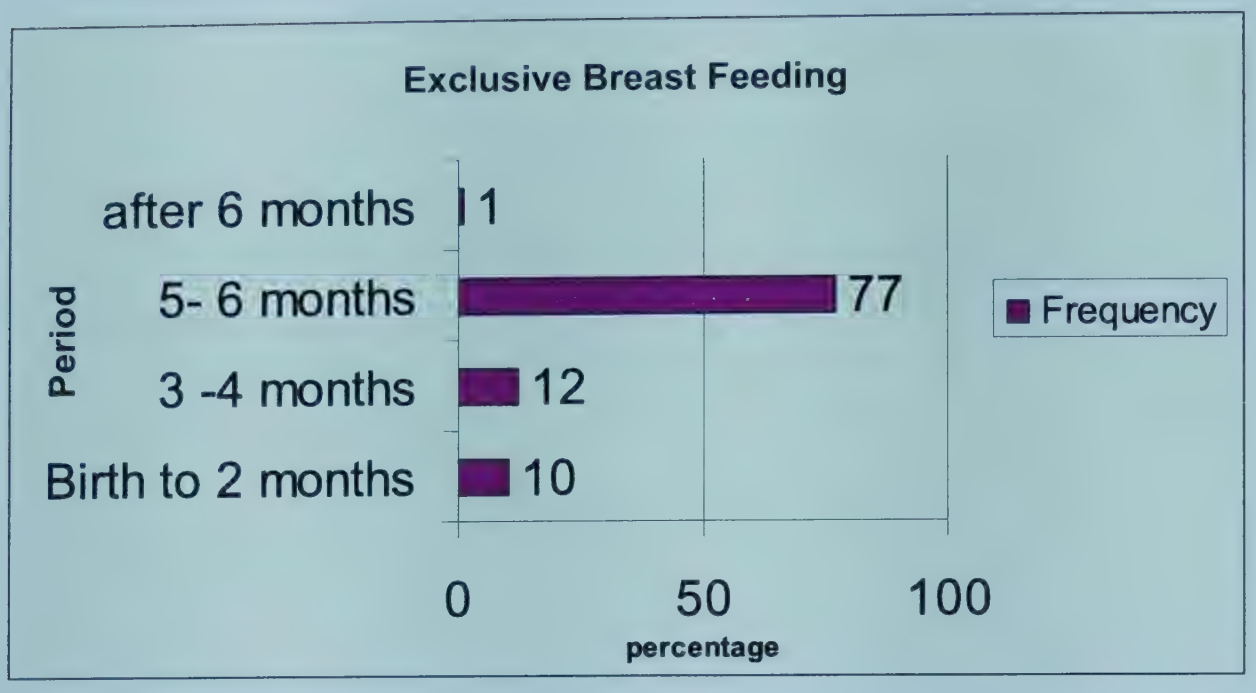
However, many women went on to give nothing but breast milk for varying periods of time after the prelacteals were given as shown below. Out of the 102 children who received prelacteal first and then were breast fed, 61% of children received breast feed without any other liquid accompany till 6 months.



(Figure 38)

However, many women went on to give nothing but breast milk for varying periods of time after the prelacteals were given as shown below. Out of the 102 children who received prelacteal first and then were breast fed, 61% of children received breast feed without any other liquid accompany till 6 months.

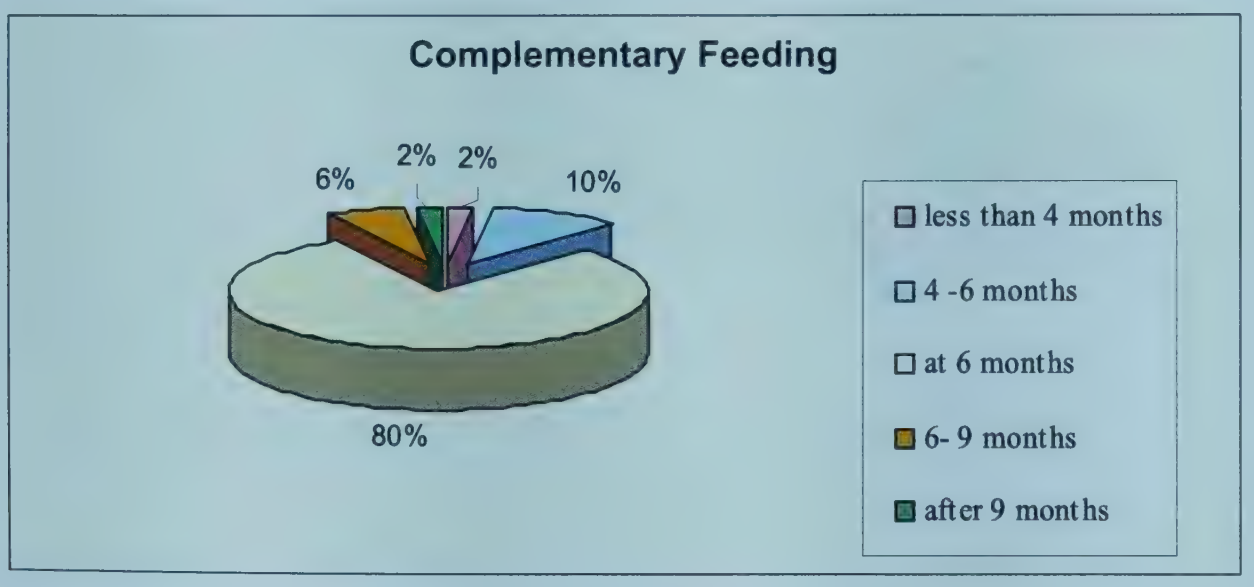
Out of the rest of children who did not receive prelacteals (94 children), 77% (72 children) received exclusive breast feeding for 5-6 months. Thus, there seems to be a stronger tendency between those who do not give prelacteals to exclusively breast feed for 6 months.



(Figure 39)

In total, only 37% (72) of the children, out of 196, were found to be exclusively breast fed for 6 months if one strictly follows the definition of exclusive breast feeding.

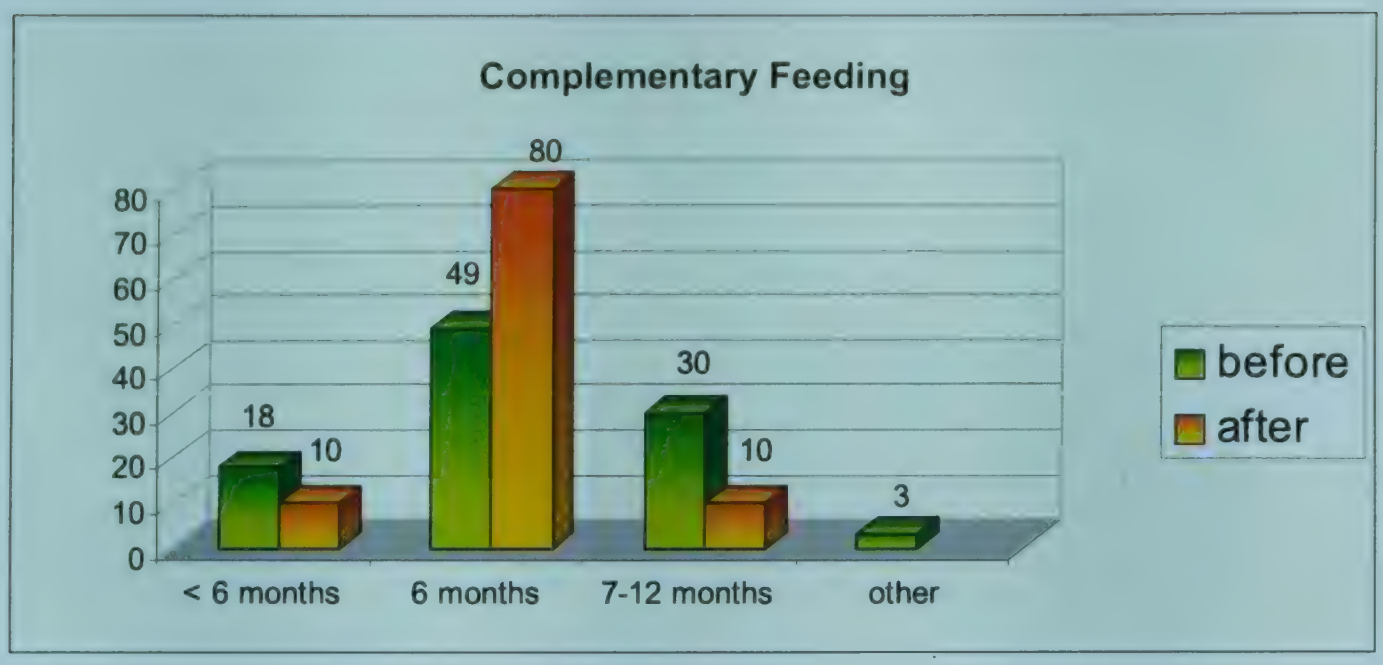
Complementary Feeding at Six Months



(Figure 40)

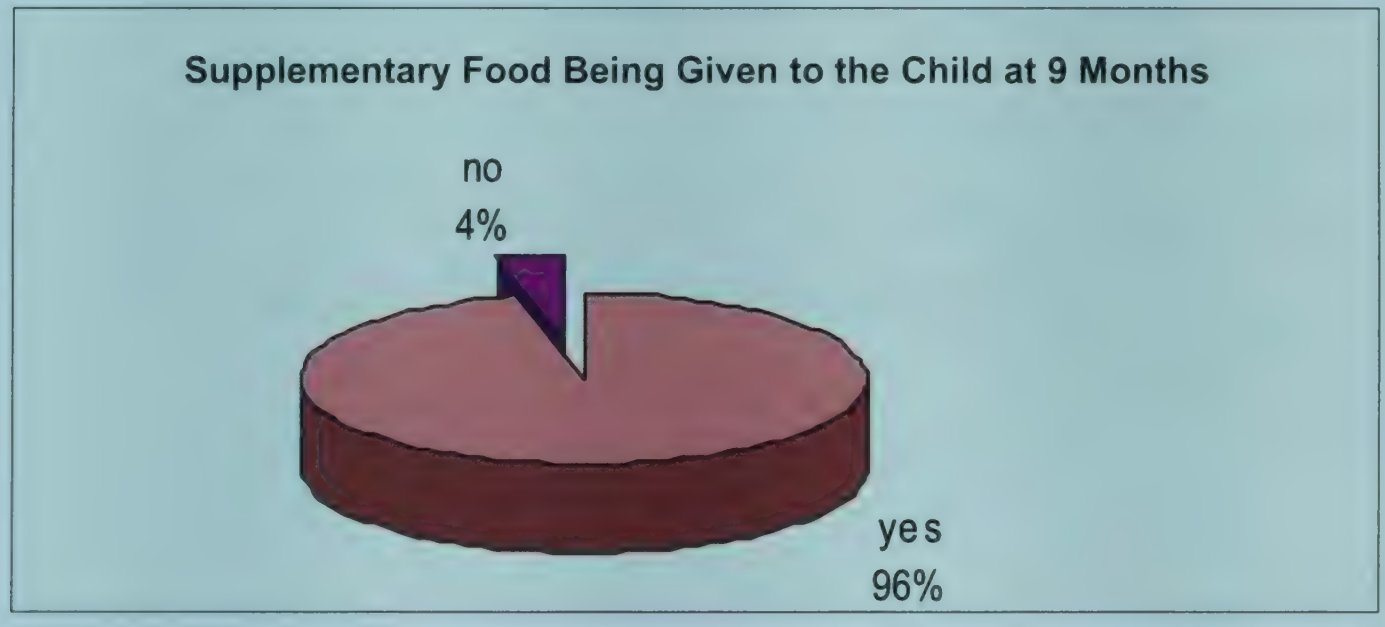
It appeared that the message to introduce complimentary food at six months was widely and well received.

This was also a marked improvement from the baseline of 49%.



(Figure 41)

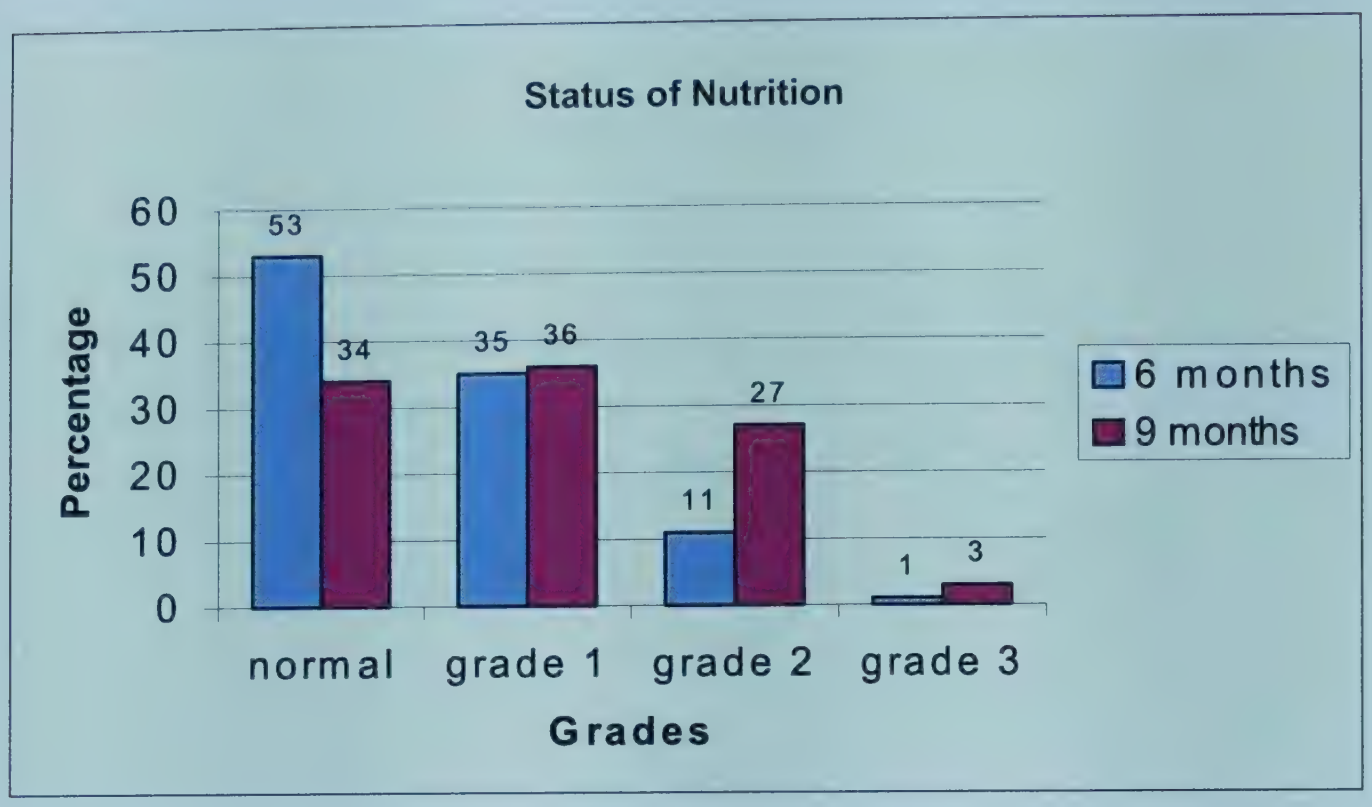
However, a small number of children remained without complementary food even at 9 months.



(Figure 42)

Malnutrition

Despite the fact that a large number of children received exclusive breast feeding after the initial prelacteal and complimentary feeding was generally started at 6 months and almost all children were receiving it by 9 months, malnutrition figures and trends were alarming. The downwards slide was particularly visible from 6 – 9 months.



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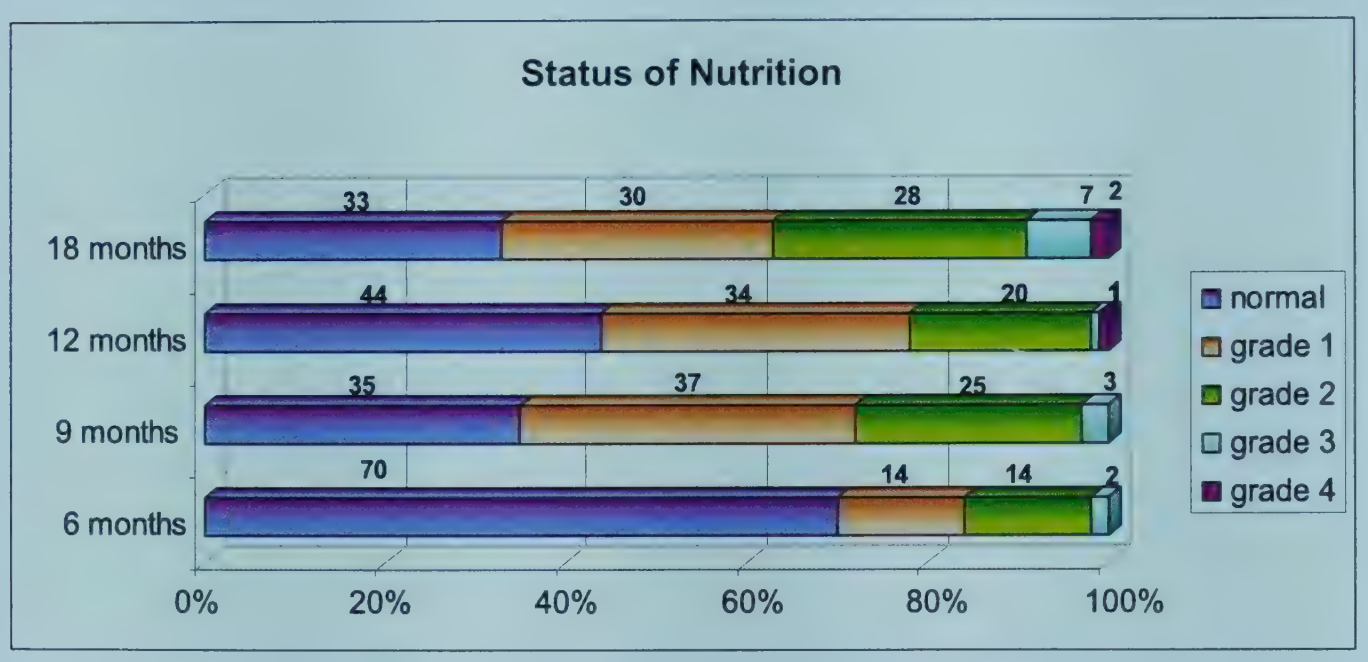


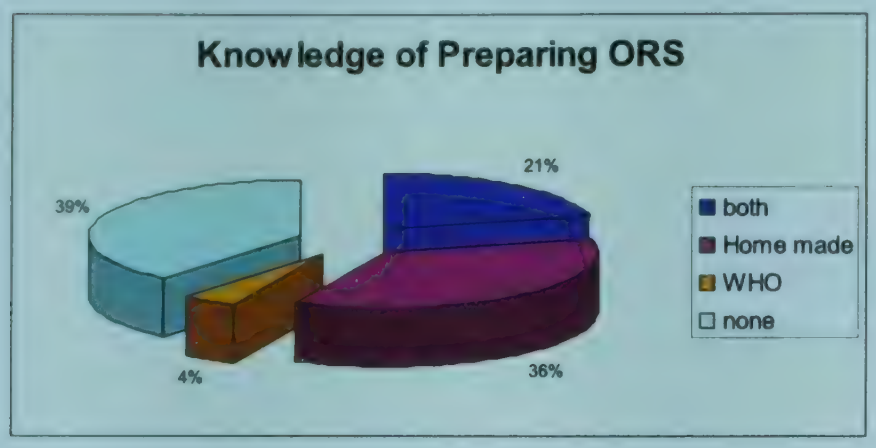
(Figure 44)

This trend was ascribed to the high frequency of diarrhoea and other illnesses, lack of childcare facilities to support children of working women as well as lack of access to supplementary feeding through a programme such as the ICDS.

5. II.d. Impact on Management of Common Illnesses

It is well understood that dehydration from diarrhoea and acute respiratory tract infections remain the largest causes of mortality and sickness in children under the age of six years. Children who are malnourished are at greater risk of contracting these and dying from them, and conversely, they are themselves major causes of malnutrition.

Thus, the facilitators were also expected to intervene by delivering appropriate messages about diagnosis, home management and referral, as well as facilitating this management. Research findings suggested that these interventions did have some impact.



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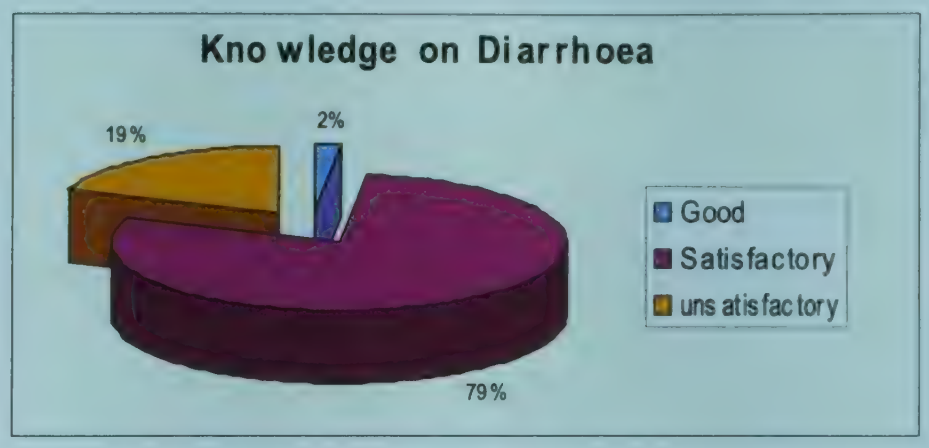

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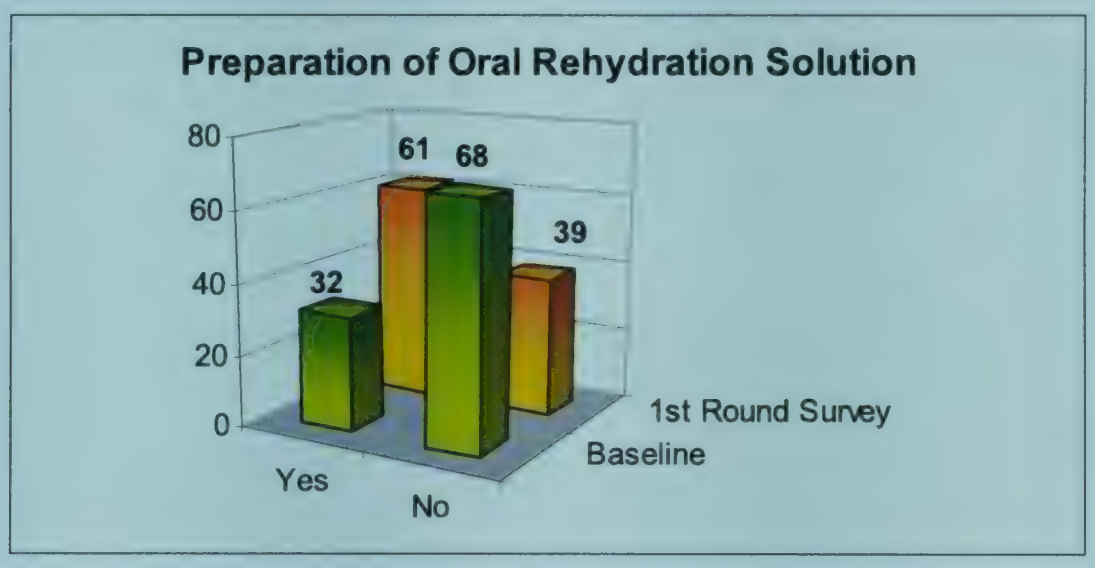

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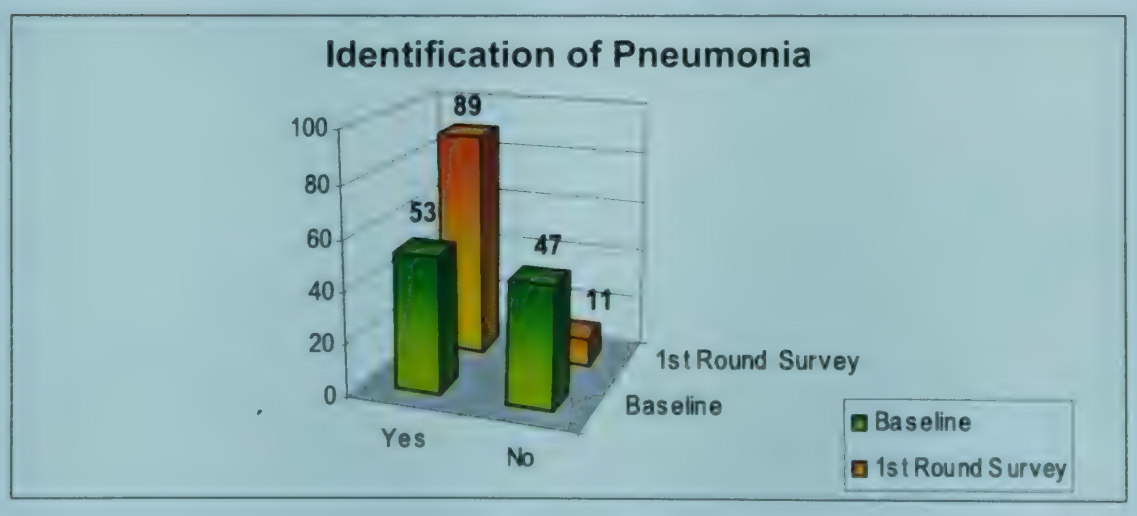
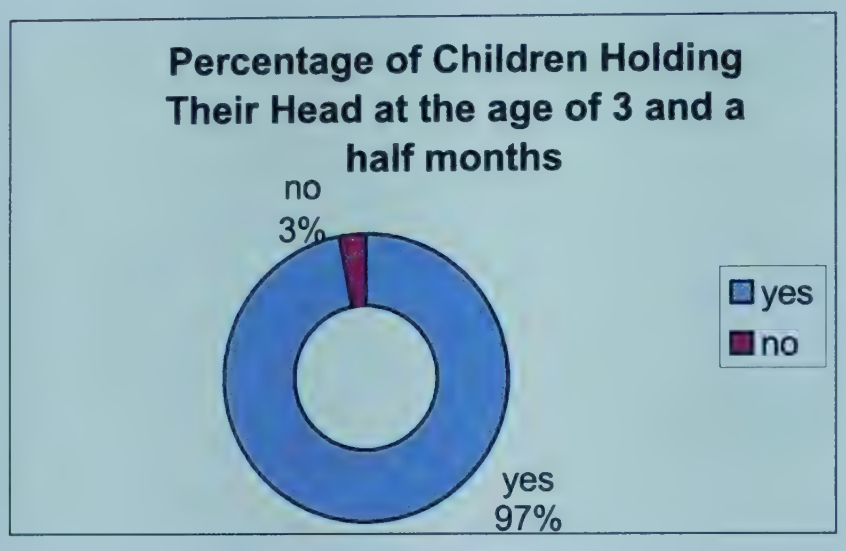


(Figure 48)

5. II.e. Development

On the whole, children did well in terms of achieving non motor milestones though motor milestones were found to be delayed by a few months mostly due to malnutrition. As children with delay were followed up they were noted to achieve their milestones with time.

In the entire sample, only one child was found to have disability – a child with congenital deafness.



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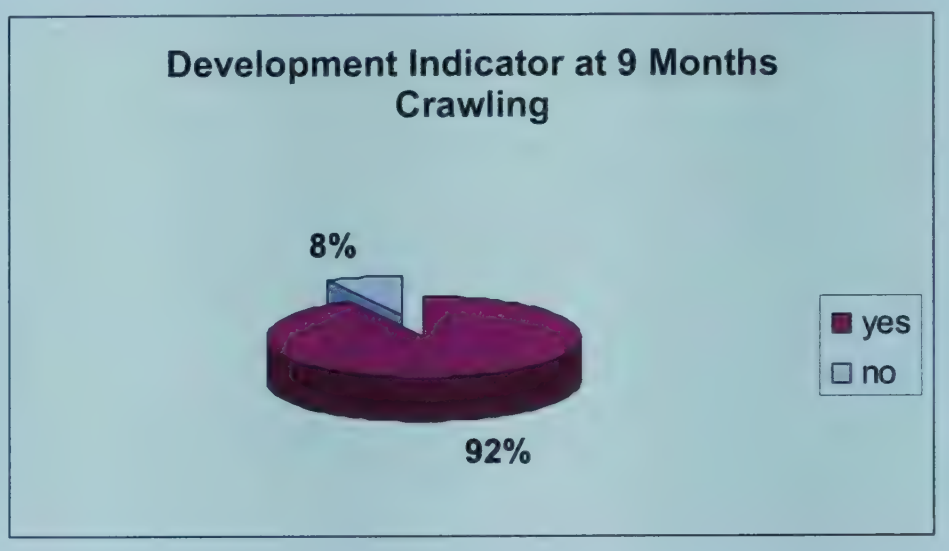

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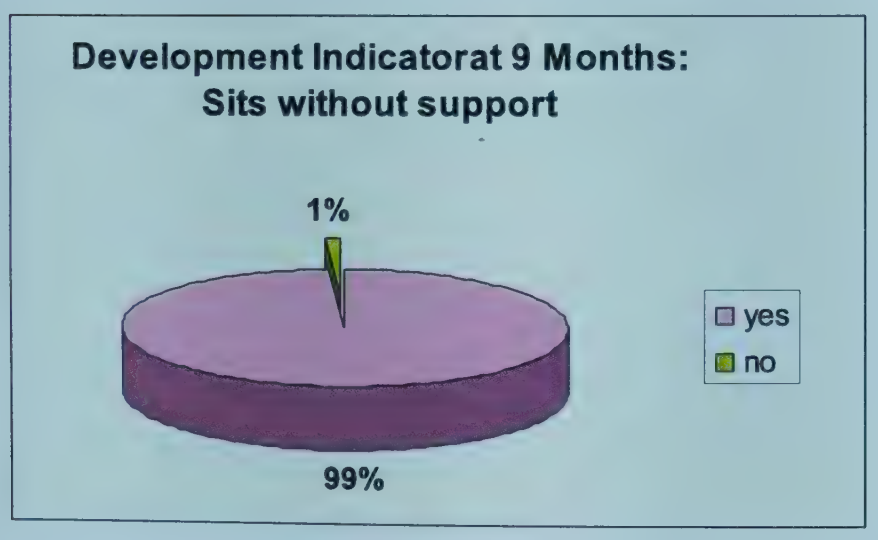

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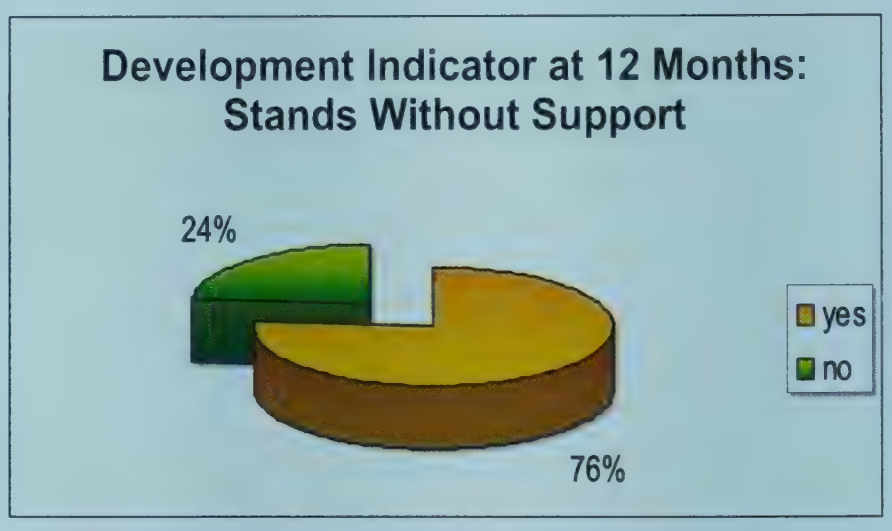
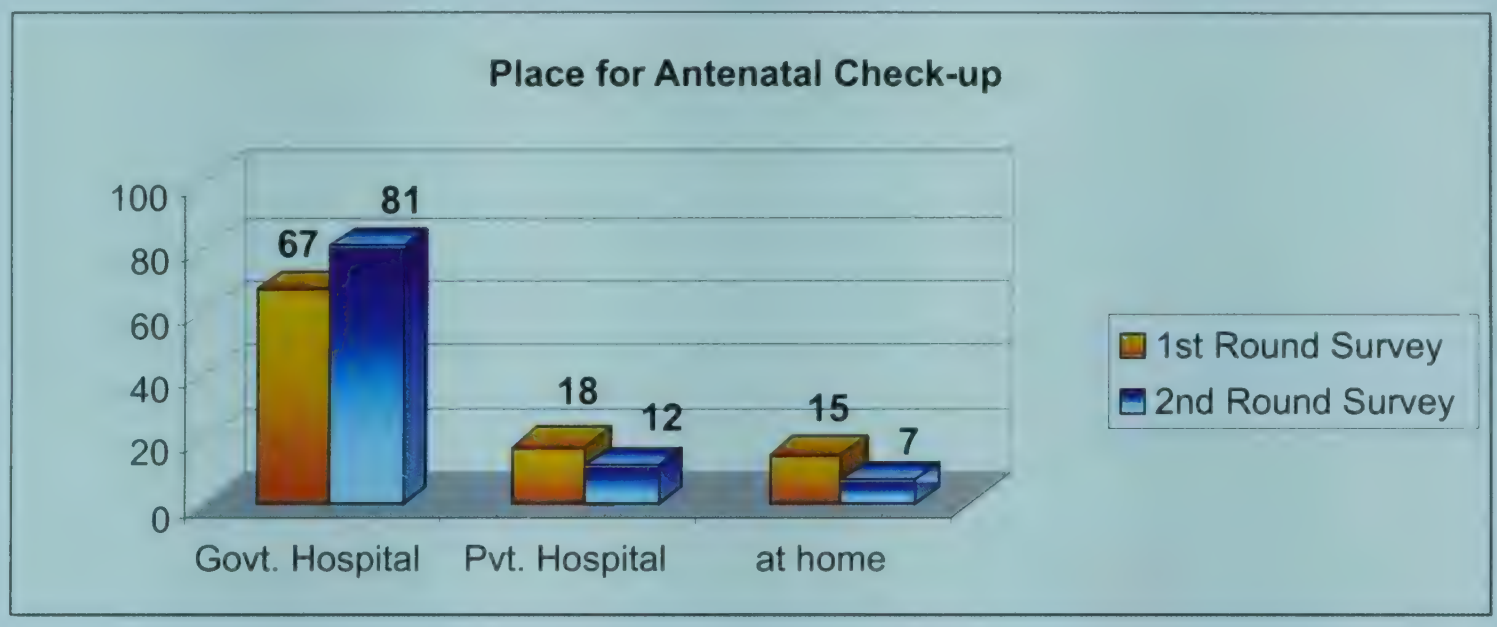


(Figure 52)

6. 2ND ROUND DATA

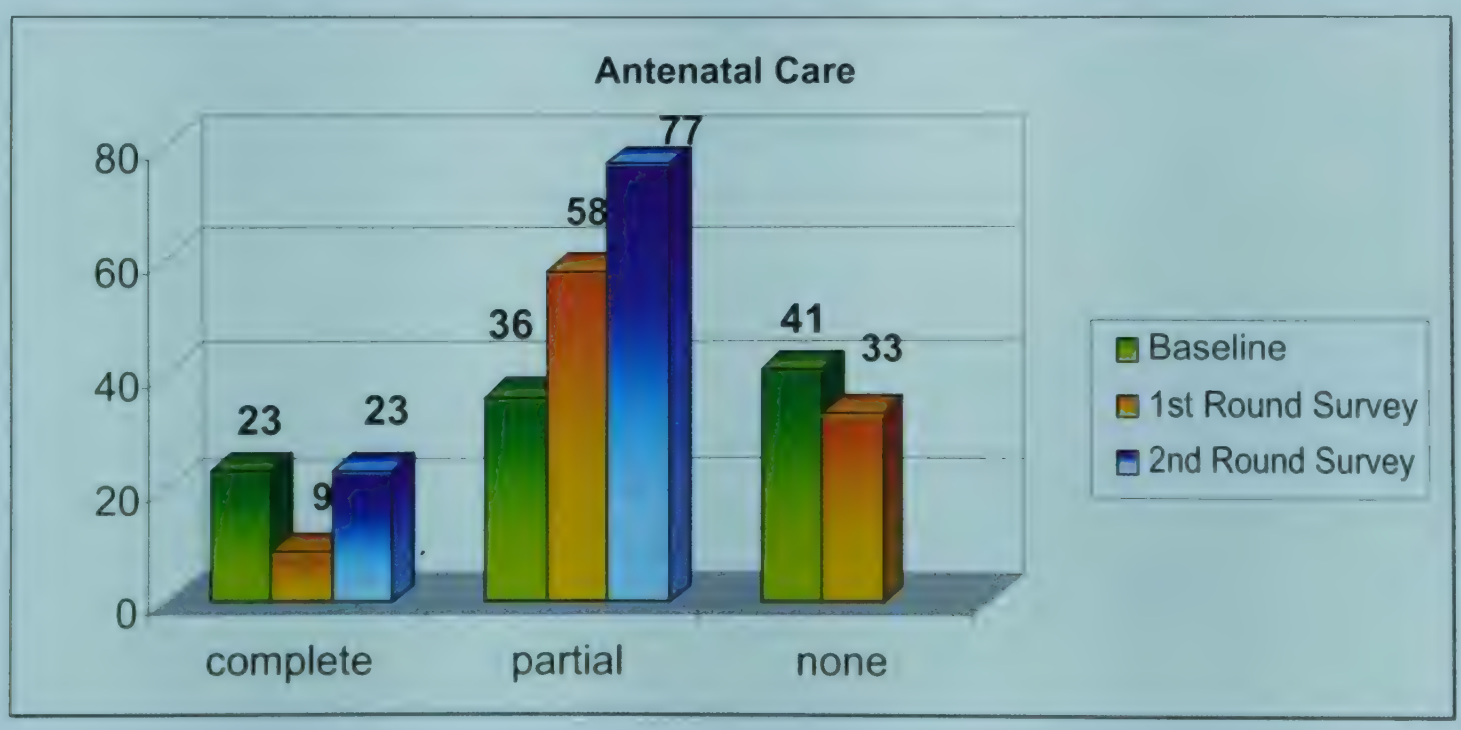
As discussed above, during the course of this intervention, at the time when most children were nearing 18 months of age, some of the women amongst the selected families got pregnant again. It was decided to repeat the exercise of intervention and see if there was distinct improvement in impact during this second round. Of course, the 'sample' was far smaller, at 30 women. The following findings were noted:



(Figure 53)

More women opted for antenatal check up at the government facility during the second round.

There were also improvements in the quality of antenatal care as evident below.



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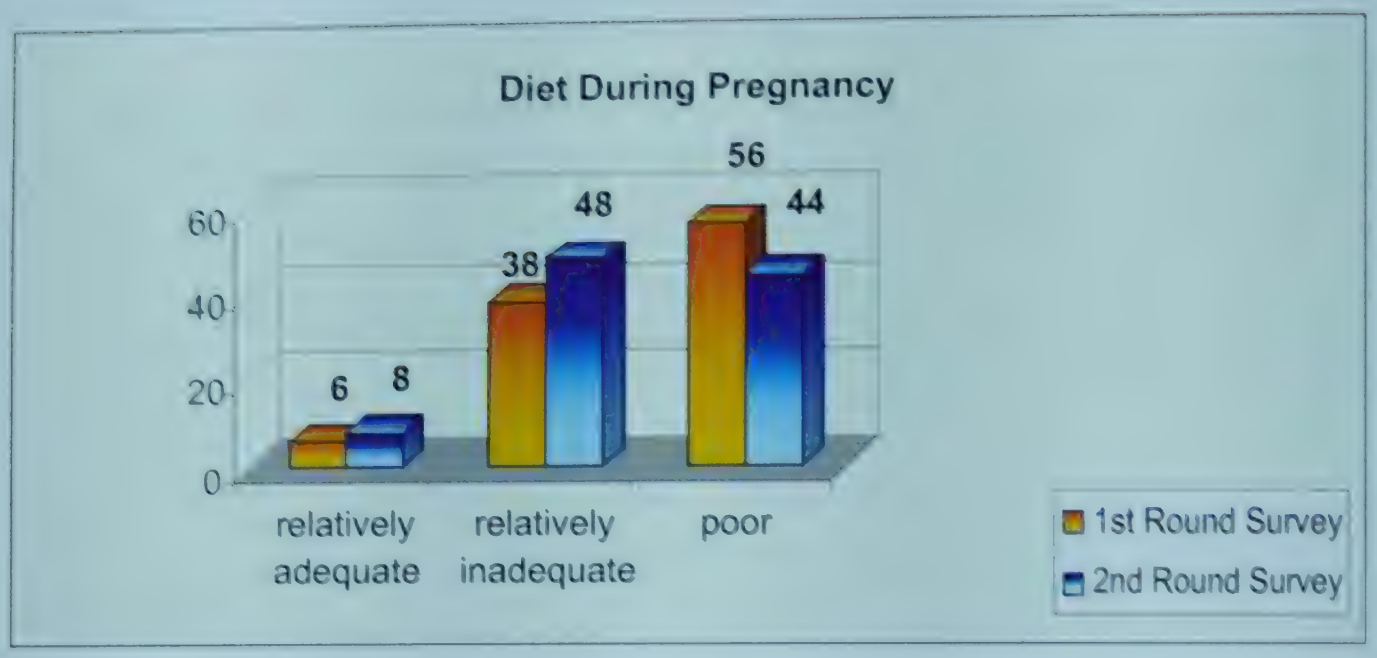

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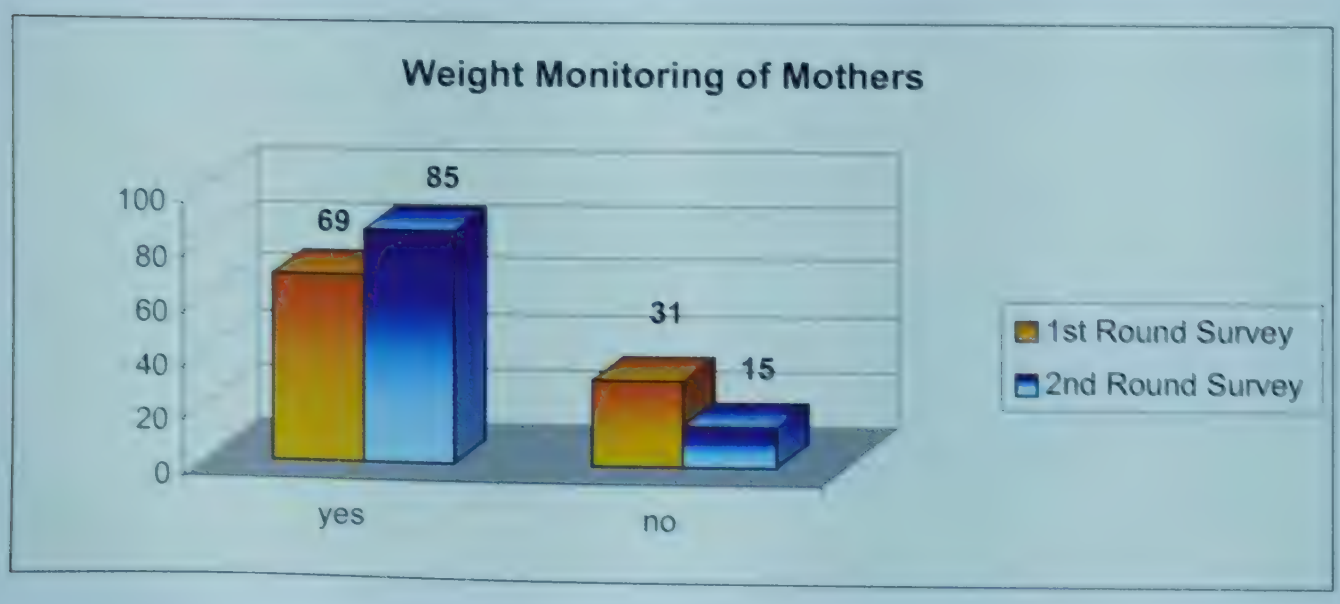

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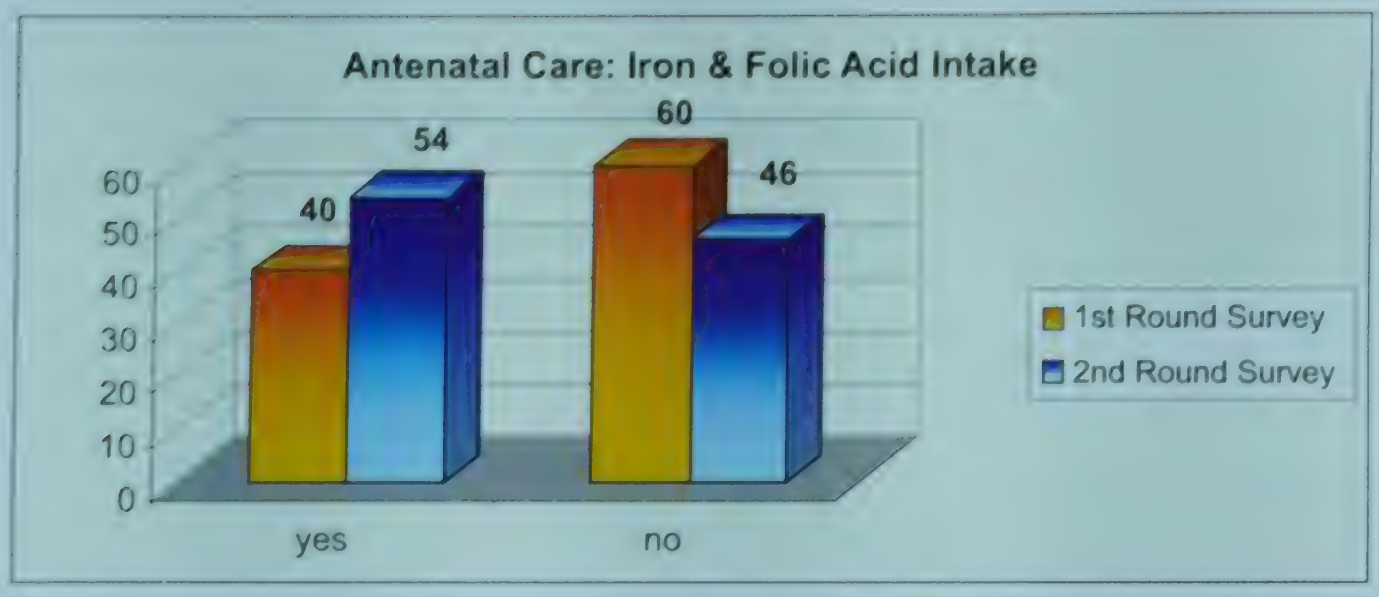

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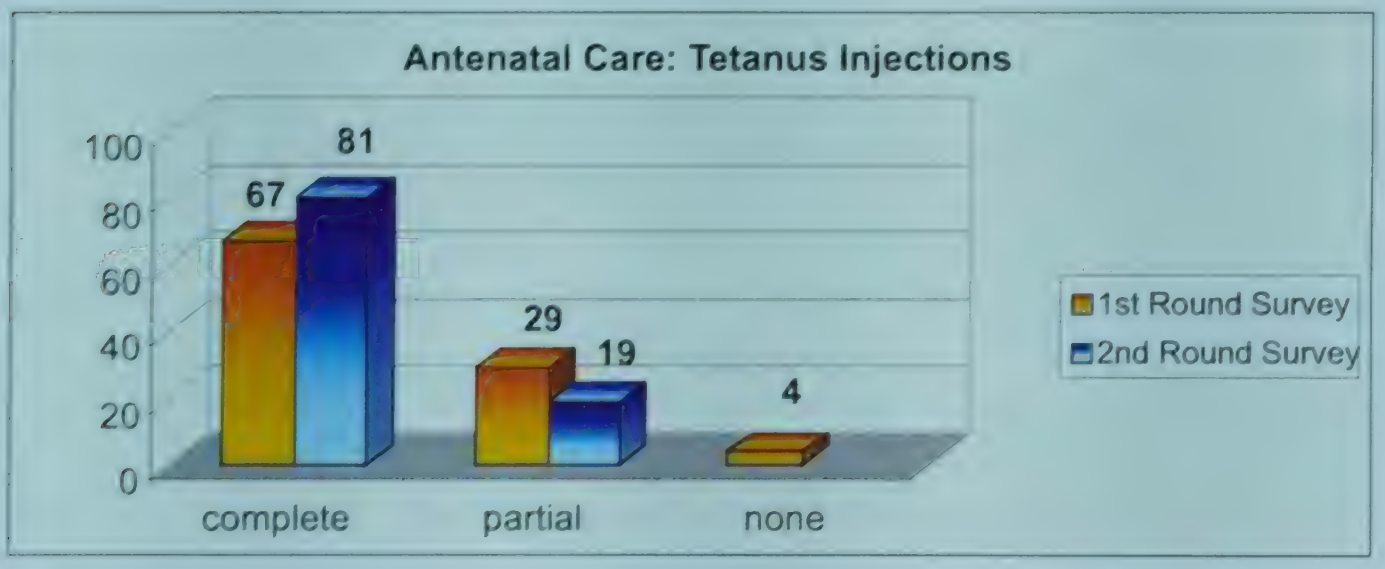
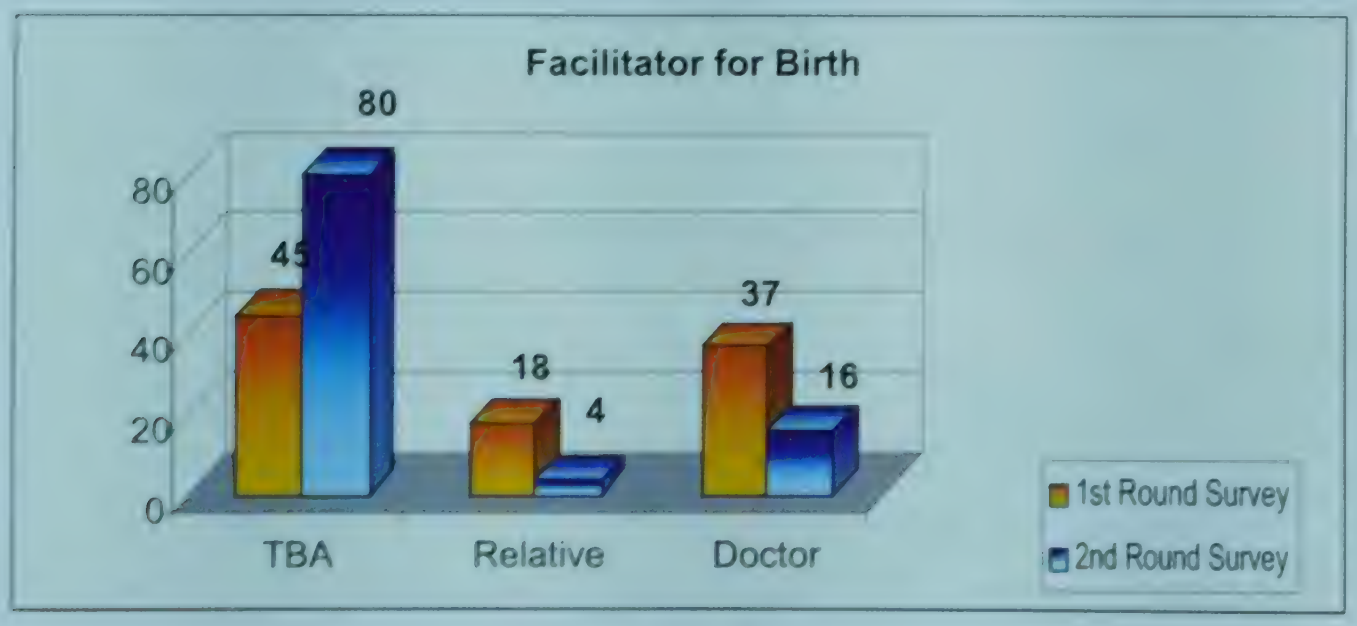


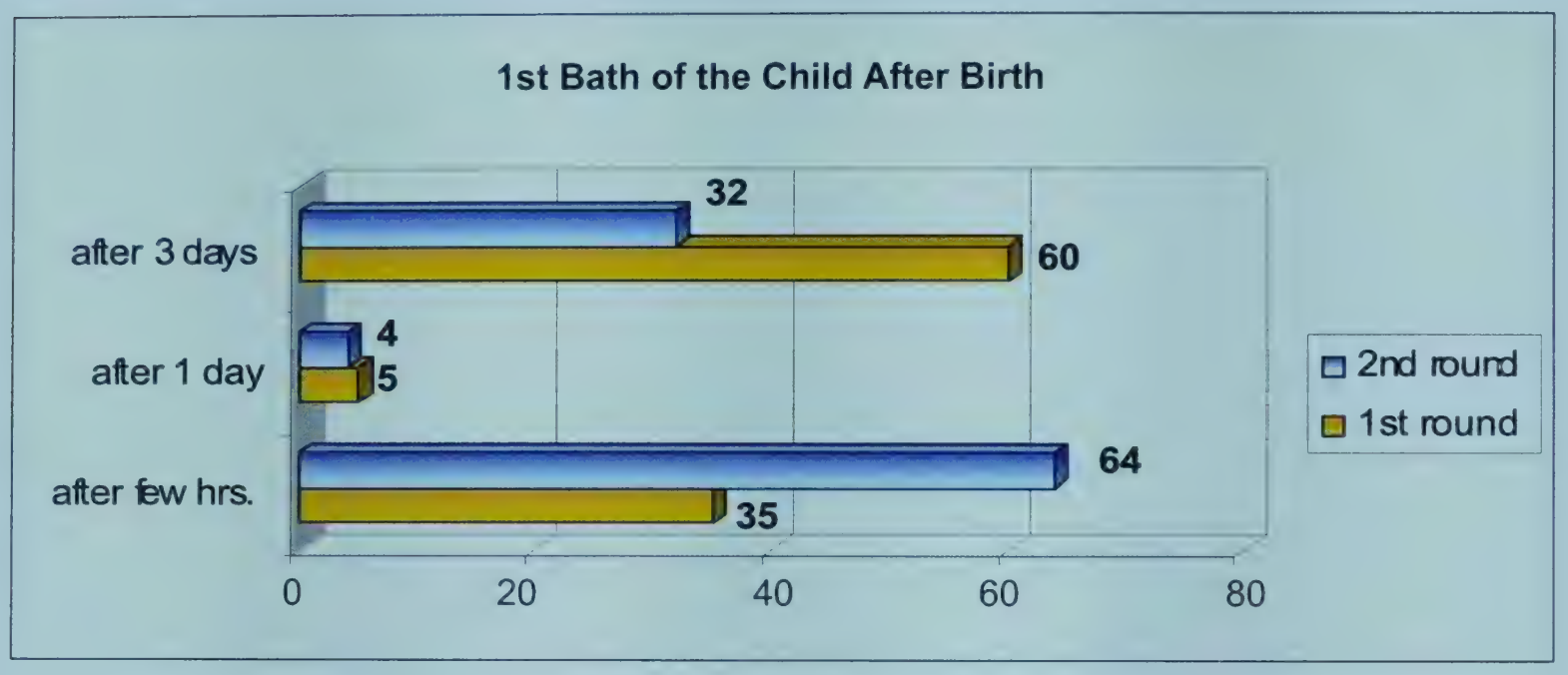
(Figure 59)

However, when it came to deliveries, a higher percentage gave birth at home!



(Figure 60)

In other parameters also, gains were made in immunisation, exclusive breast feeding and not giving prelacteals whereas the traditional practices of early bathing and discarding of colostrum seemed to regain their place as compared to the first round!!



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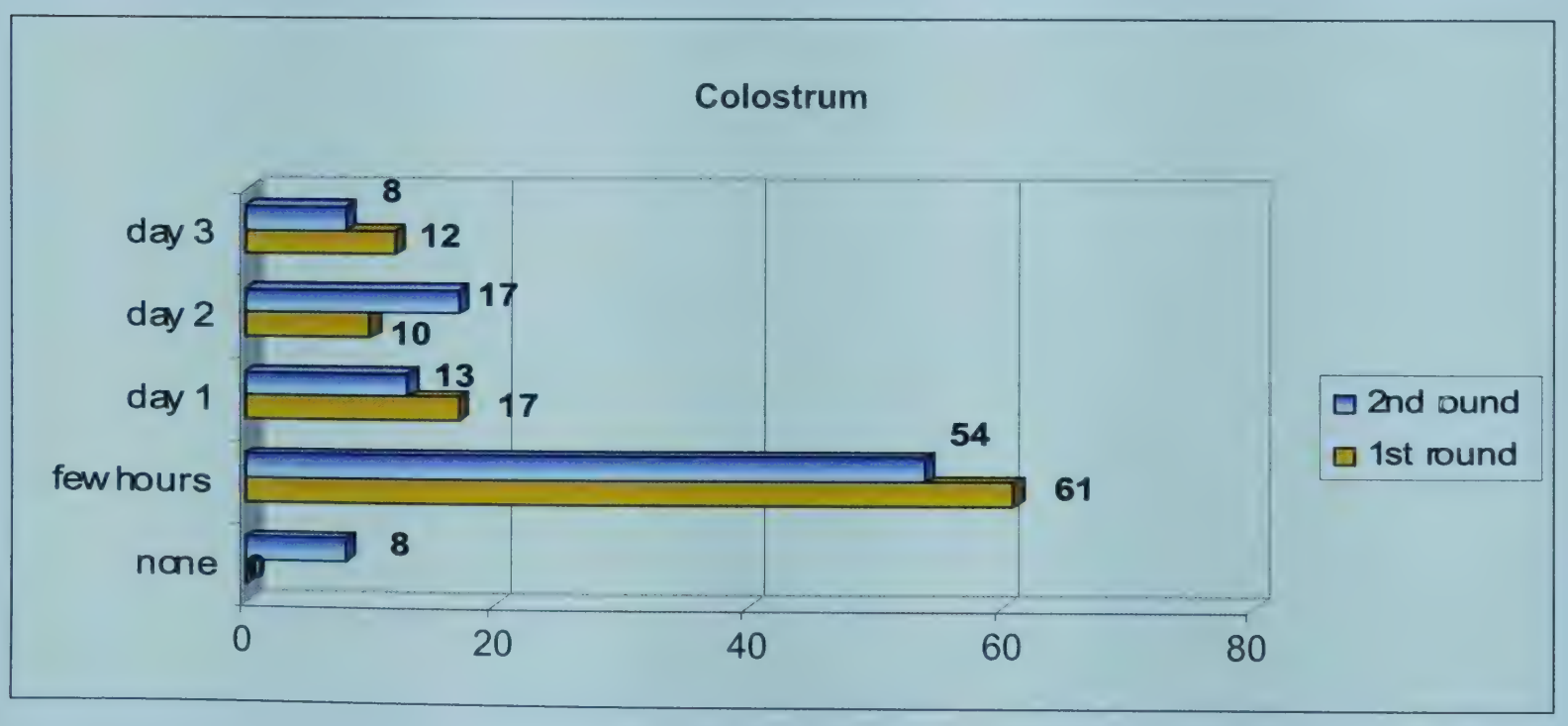

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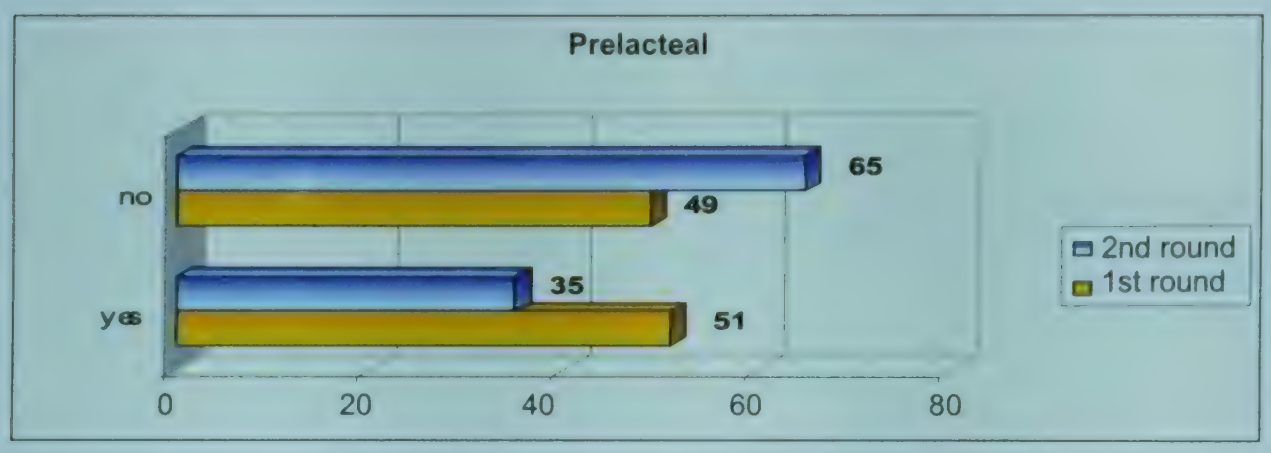

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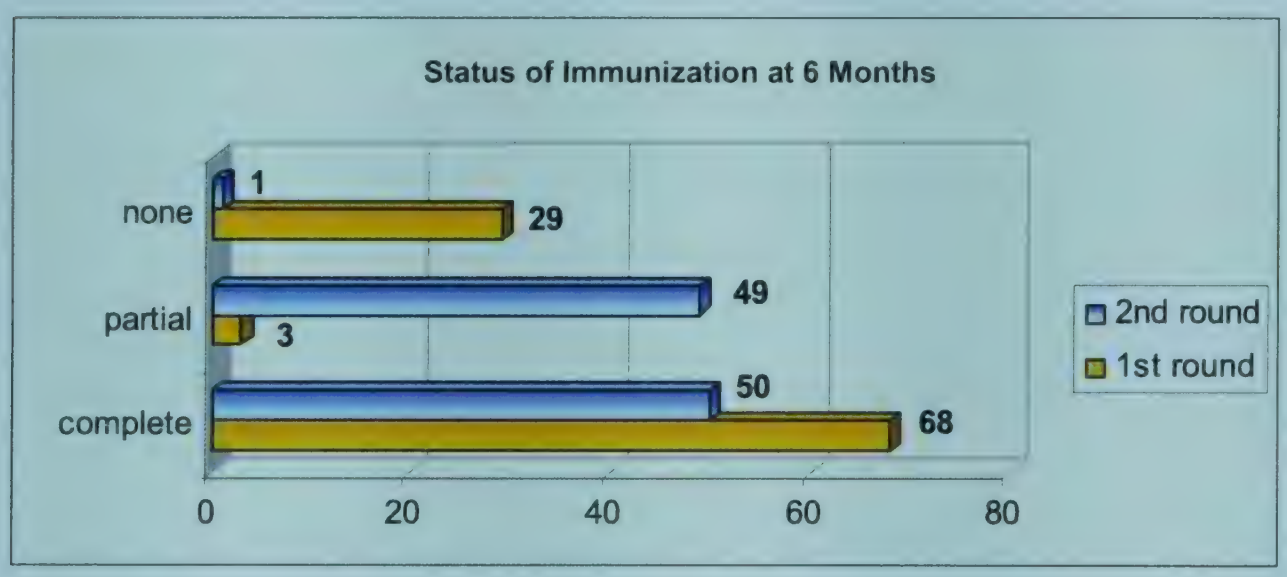

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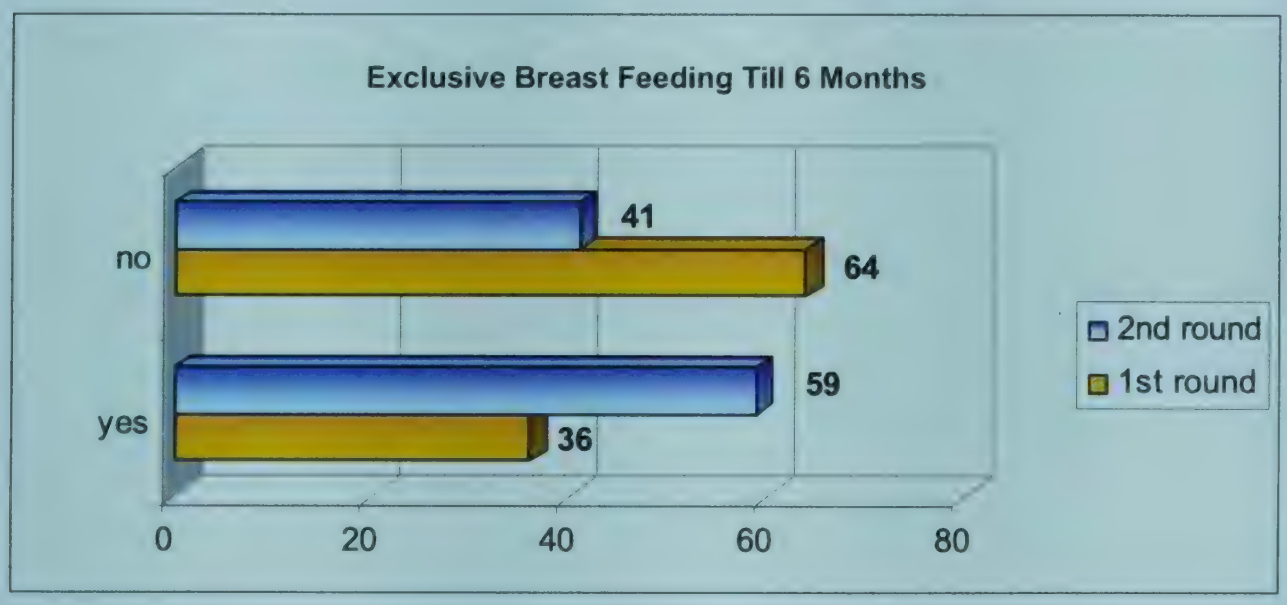


(Figure 65)

This might be a result of the greater focus on areas of relatively little success in the first round (exclusive breastfeeding) at the cost of other issues. The business of immunisation had already been systematised by the fact that the ANM is now making regular visits to the area. The deterioration in data may also be related to a pull back in programmatic support and changes in the support team. Thus, it does point to the great hold of certain traditional practices and the need for sustained behaviour change communication of high quality to make a lasting dent.

7. OTHER INTERVENTIONS TO SUPPORT ACTION RESEARCH

The study revealed that some of the information gained, required further probing either because the quality of the data was ambiguous or because there were contradictions between two sets of data such as status of prelacteal feeding and status of exclusive breastfeeding. Hence re training was organised and supplementary forms were prepared and fed into the process to further validate and clarify findings. These were:

Diarrhoea Management: definition of diarrhoea, household measures and ORS preparation. 144 forms were filled with the selected household, to gain information on how the community tackles the problem of diarrhoea. Analysis of the information collected helped us to identify various problems in their practices, gaps in information and inadequacy in the treatment provided. Hence visits were paid to all the household and information on the same was disseminated.

Pneumonia Management: 154 forms on pneumonia management were filled. The analysis showed that a majority of people knew how to identify the disease and treatment for the same.

Supplementary Diet: exclusive breast-feeding, prelacteals, colostrum and supplementary diet. Information gained through these forms helped in portraying a clear pictures and identifying the areas of interventions.

In addition, the following activities added some value to the work on linking with health services and behaviour change:

Monthly meetings were organized with the community paediatrician to discuss the health conditions of the children in community and special emphasis were laid on follow up of general health checks and the children with grave conditions like acute diarrhoea and nephrotic syndrome.

Immunization: with the support of the ANM from the neighbouring PHC and facilities of immunization being available within arm's reach has motivated mothers to avail the service for free 145 children were immunized.

Growth Monitoring: regular growth monitoring of the children is in the process. The analysis of growth charts revealed children in different grades of malnourishment; the main reason behind it has been recurring diarrhoea due to poor quality of water. To ensure proper growth of the children in future, referral services are being provided to the women and counselling of mothers is being done about the importance of nutrition for growing children and the diets required to ensure this.

Health Report Card: As the action research neared its completion, it was decided to introduce health report cards for families to keep which would record information on all health aspects and inputs from the Doctors and the staff of Mobile Crèches.

Birth Registration: after meeting the 100% target set in the study for Birth Registration it was found important to disseminate the information about the same in the community and facilitate community action for the same.

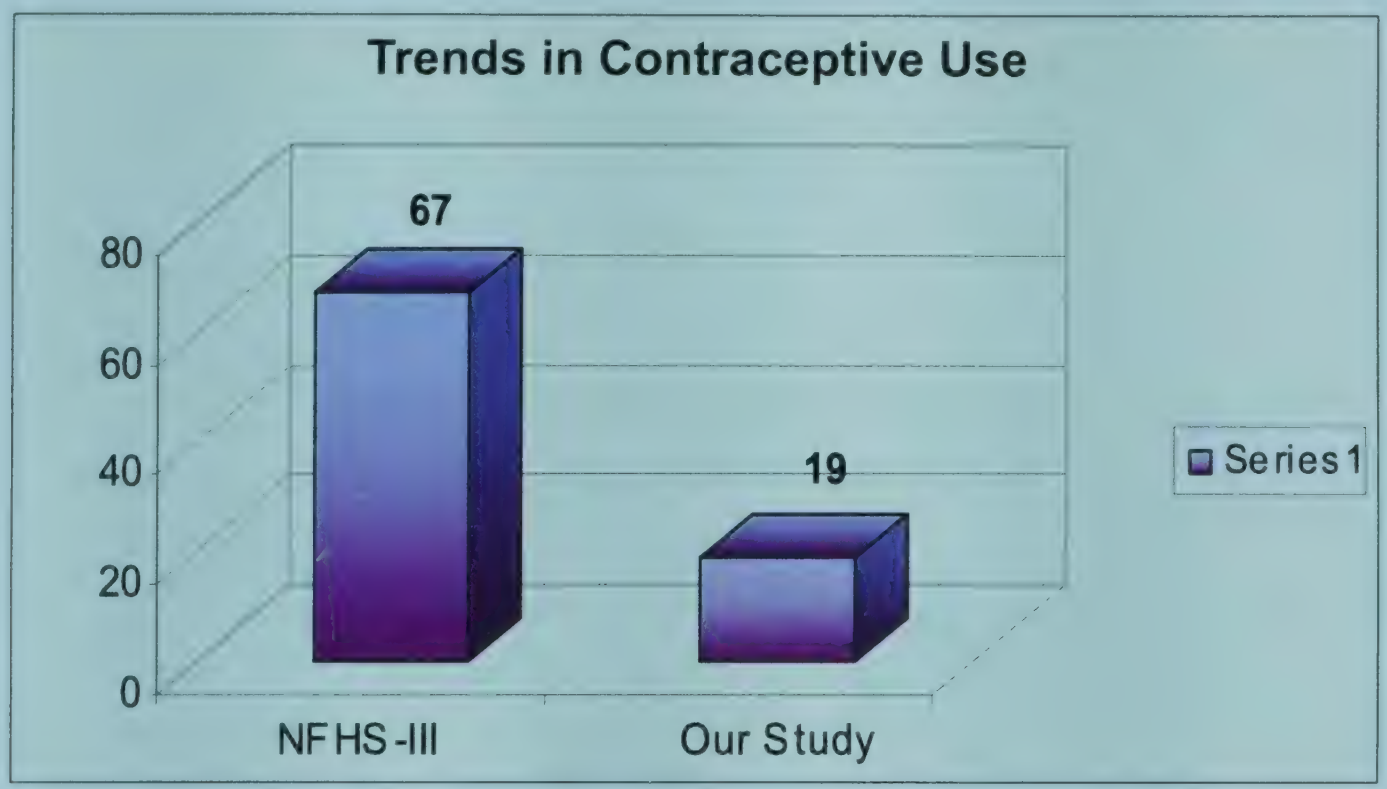
Training of Facilitators: there was quite a lot of flux in both the team of facilitators as well as the team of trainers and supervisors. This necessitated many rounds of on-the job training by the consultant and senior trainers.

Mobility of families under study: Since the beginning of the study there was a constant decline in the number of families, and it was found to be important to study the reasons for the same. During the analysis it was found the one of the most common reason is either the families have returned to the village or they have shifted from the area.

Family Planning Measures: after a continuous awareness generation on the side effects of a large family, 40 women started using contraceptives and 3 underwent tubectomy, in order to avoid unwanted pregnancies in future.

8. COMPARISONS WITH NFHS III DATA

Data for the Union territory of Delhi was collected by the national family health survey 3 and released in 2006. It is worth noting that this data is not specific to slum / poor populations and represents the average including the very well off middle and upper middle class with sufficient access to health care services. Nevertheless, where some indicators were concerned, the efforts by the facilitators showed distinct improvements as compared to the Delhi average.



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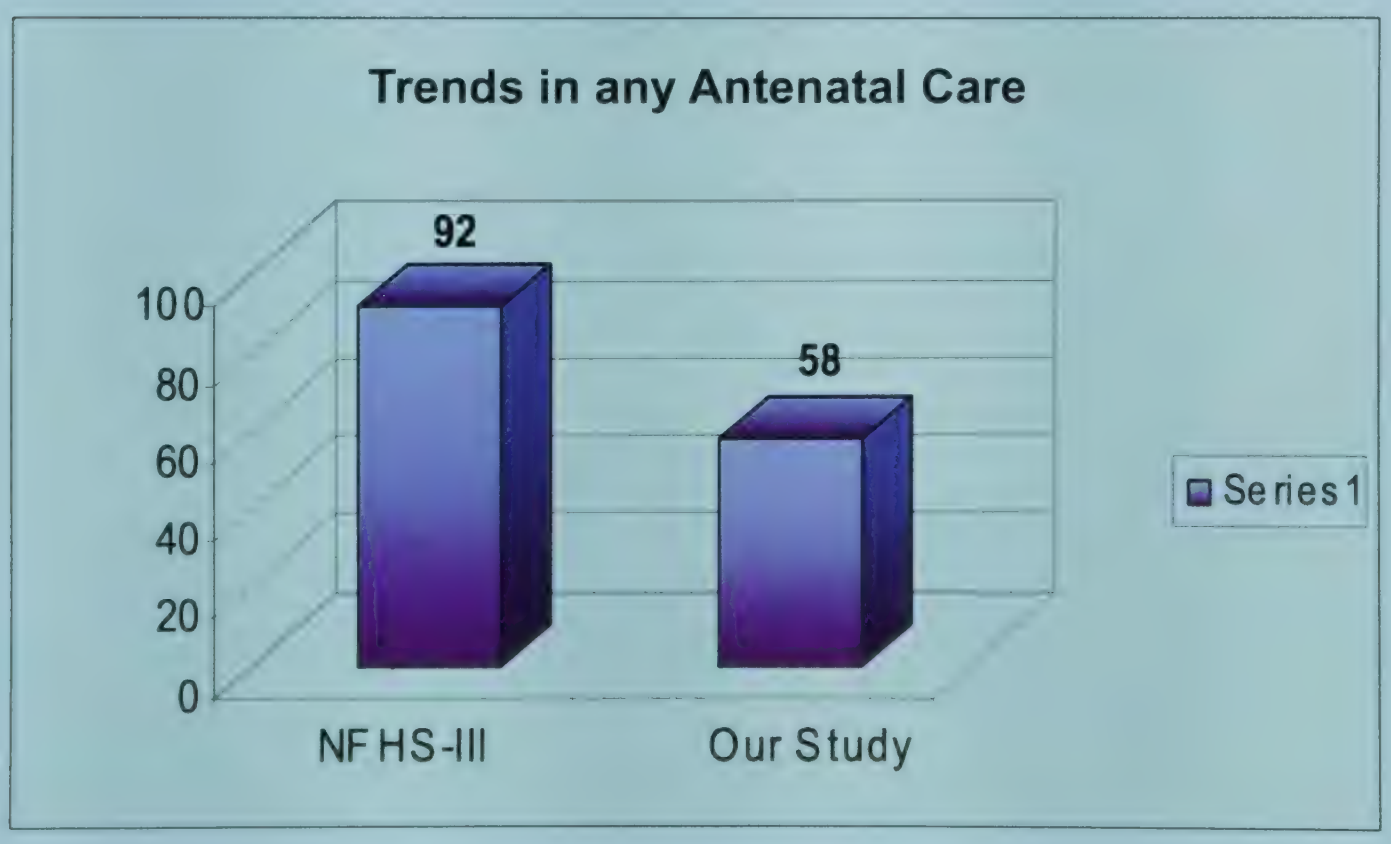

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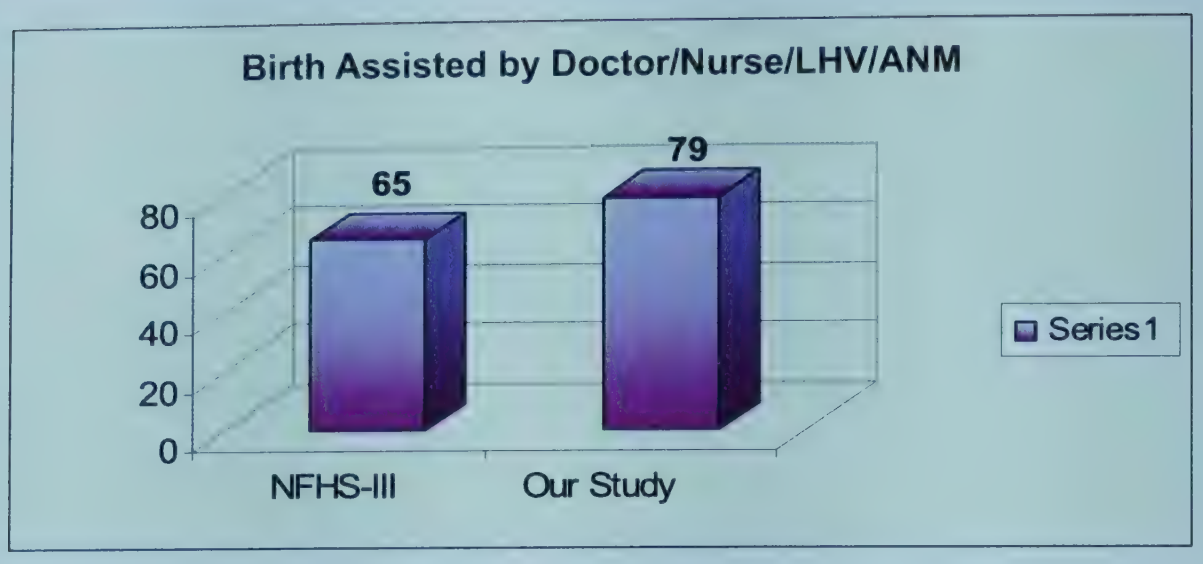

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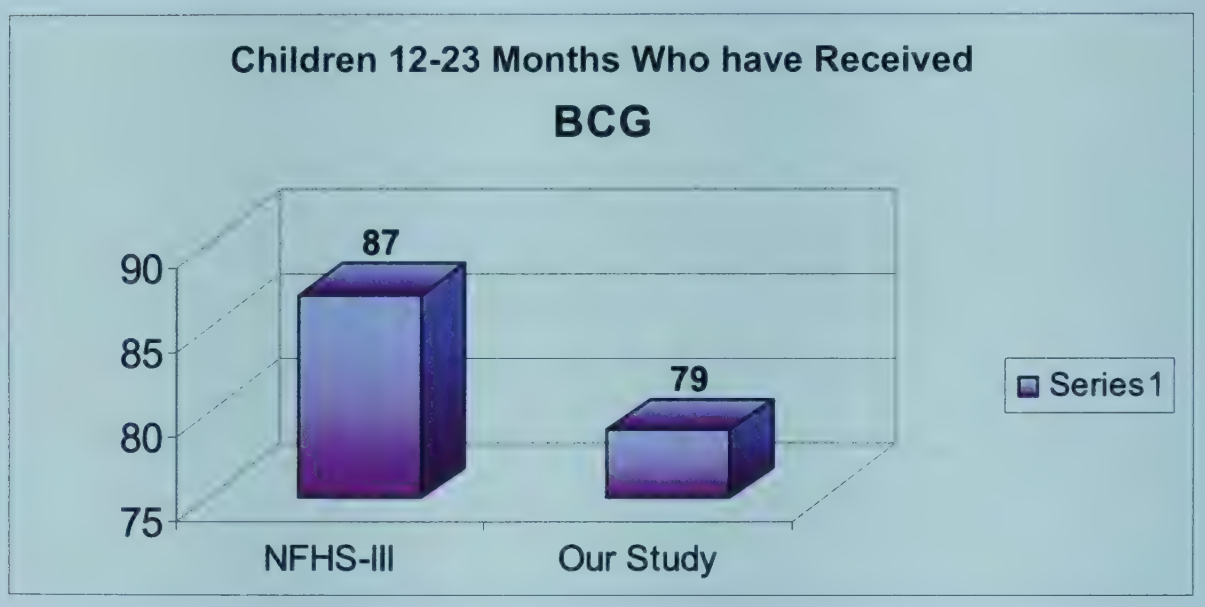

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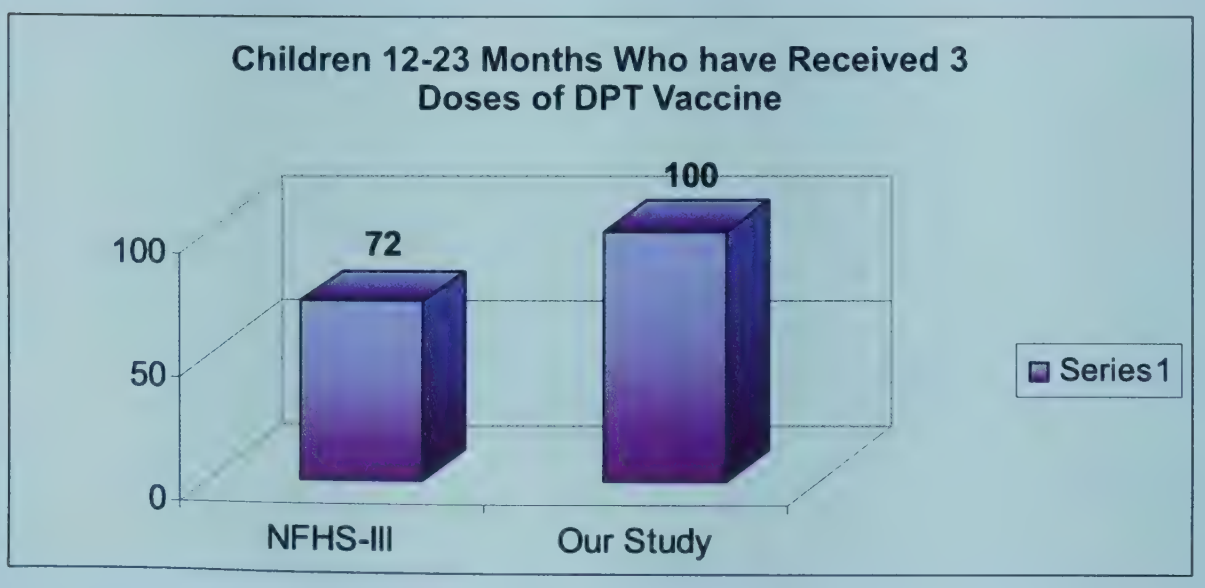

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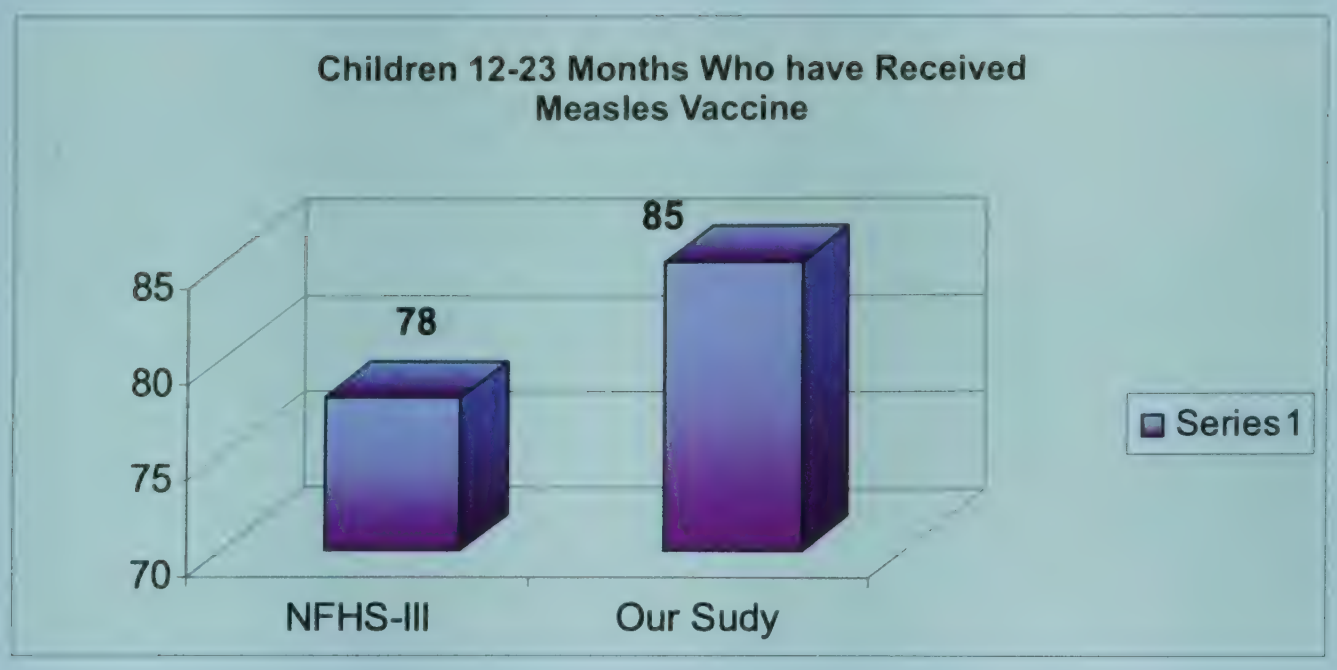

(Figure 71)

Infant Mortality

9 babies died within the first year of life giving an IMR of approximately 35 (The total sample size was variable all through the period of study; NFHS 3 – IMR 40). The contributing causes were the expected ones of low birth weight, malnutrition, infection and accidents. On further analysis, lack of support for overall care as well as very poor access to health care was clearly evident. One child died of nephrotic syndrome and another of disability related causes. Two children appeared to have died of Sudden Infant Death Syndrome.

9. SUMMARY

Various strategies have been tried to intervene positively for the health and well being of children by organisations such as Mobile Creches. These include the provision of direct services, working with families for greater awareness on issues related to ECCD, working with communities to provide support for these issues and also facilitating access to government services and various entitlements.

All these interventions hinge upon the facilitation by person with the requisite skills and knowledge to accomplish these diverse tasks. Clearly, the maximum impact can be expected with the use of multiple strategies rather than a single one.

Short of providing direct services, this 2 year long intervention in an urban resettlement colony used a combination of all these approaches by a team of trained facilitators, supported by a group of trainers including a community child health specialist. The results have been encouraging as can be seen from the table below.

Target Achievement (Table-1)

Parameters	Before Intervention	After Intervention		Target	NFHS III
		1st Round	2nd Round		
Complete Antenatal Check-up	19%	33%	23%	100%	74%
Tetanus Injection	50%	67%	81%	100%	
Safe Delivery (either through TBA or Institutional)	52%	79%	80%	100%	60.7%
Birth Registration	26%	100%		100%	
Birth Weight	-	33%		100%	
Colostrum Feeding within 1 hr.	46%	34%	29%%	100%	19.3%
Prelacteals	51%	50%	35%	None	
Exclusive breast feeding	44%	37%		For 100% mothers	34.5%
Immunization as per Government norm	47%	87%		For 100% mothers	63.2%
Status of malnutrition	Delhi figures 33%	67% at 18 months		None	33.1% under 3 years
Knowledge and skill for ORT	32%	80%		100%	34.4%
Ability to recognize anaemia	53%	89%		100%	93.1%
Vitamin A dosage	42%	77%		100%	17%

Specially, it was possible to make gains on immunisation and management skills for common diseases. Moderate impact could be seen on colostrum feeding and delaying the first bath of the child. However, little impact could be made seen on issues such as exclusive breast feeding and prevention of malnutrition. Nevertheless, impact which was not reflected in better figures could be seen on a case-by case basis as illustrated in the case study below.

TIME LINE

➢ **September- March 2003**

- ***Getting to know the community:***
  - Before setting out to work in the community, information about Khadar, resources available, NGOs working in the area and the problems faced by the community was gained.
  - A transact walk was done in the community and the women, with whom we had a contact earlier were searched for.
  - A survey was conducted to find the number of dropout children in A-1, A-2, B-1 and C-Pocket. 450 children were found to be between the age group of 6-15 years and single block, A-1 was selected for the focused interventions.
  - 22 women were identified for training on Crèche Management.
  - Large number of community meetings was held on the various diseases affecting the children as well as adults like: diarrhoea, T.B., fever, pneumonia, etc.

- ***Capacity Building:***
  - Selection of 2 facilitators from the community was done and their job description was given along with their appointment.
  - A 2-day workshop was organized in the Mobile Crèches office, on the Capacity building of the staff based on the various aspects of health, life threatening diseases affecting children and community work. An action-plan was drawn for the following months.
  - Organized three family/ mother's meetings on ECCD, during this time frame and shared information informally collected and provoke discussions around it.

- ***Community Communication:***
  - A theatre presentation on Environmental Cleanliness was presented in the community.

➢ **April – June 2003**

- ***Community Awareness:***
  - Theater presentation on exclusive breast-feeding.

- Sensitization of community women on ECCD.
- Awareness generation amongst the community on health related issues like, immunization, hepatitis B, fits, exclusive breast-feeding, etc. based on the health problems encountered by the community

- ***Networking:***
  - Networking with the local NGOs and SHGs.
  - Meeting organized by NMPS on labour rights.
  - Meetings on basic facilities like water and electricity.

➢ **July- September 2003**

- ***Networking and Lobbying:***
  - Networking with local Government schools for admissions and strengthening of relationships with local NGOs and SHGs.
  - Awareness generation on ICDS programme and initiation of the process to open Aanganwadis in the neighbourhood.

➢ **October- December 2003**

- ***Community Awareness:***
  - 9 meetings were held within the community, with an outreach of 96 men and women on the issues related to ECCD.
  - To hold meetings with the trained women running home based crèches and to disseminate information on the importance of it amongst the community.
  - A community meeting was organized, which was participated by 27 women. The objective of the meeting was to discuss the various problems faced by them in terms of water, electricity and other facilities.
  - A meeting with a group of 13 women was held to provide information the importance and advantages of the formation of Self- Help Group.

- ***Networking:***
  - 15 meetings were organized by NMPS, with an out reach of 192 labourers, on the benefits for the labourers and importance of registration.
  - A survey was conducted in the community to find the number of children between age group of 0-6 months; by the support of old aanganwadi workers and the Mobile Crèches staff members. The survey helped in pressurizing the authorities for the allotment of ICDS aanganwadis for the much in need community.

- ***Health Initiatives:***
  - Referral services were provided for the children as well as for the adults suffering from various ailments and diseases.
  - Women with young children were linked to the neighbouring Dispensary, to ensure complete immunization of the child.

➢ **January- March 2004**

- ***Getting to know the community:***
  - Process of rapport formation with the families living in B-1 Block of MK, was initiated, as it formed the foundation for future interventions.
  - Community meetings on various issues concerning the importance of education for children, ECCD, benefits of NMPS, women of SHGs on inter-loaning and record-keeping, scholarship students on their results and future aspirations, etc.

- ***Community Mobilization:***
  - Community people participated in a Public Hearing organized at Gandhi Peace Foundation. 3 meetings were organized with the selected group before the event, to orient them on the sessions to be held and its importance.
  - 5 women from the community were mobilized, for the follow-ups from the Government agencies.

- ***Health Initiatives:***
  - Awareness was generated regarding the Pulse Polio campaign and the polio disease.

➢ **April- June 2004**

- ***Community Awareness:***
  - Background information of 1100 household in B-1 block was taken and compiled. This provided an opportunity to hold discussion on ECCD.
  - 14 dropped-out children found in B-1 block were linked to the local Government School.
  - Media 'Khilta Bachhpan' based on the issues related to ECCD was organized in the DDA office, which was seen by 103 people.
  - A meeting with the parents of the children receiving scholarship was organized. Some of the topics addressed were: regular attendance in school, proper utilization of the scholarship provided, protocol to be followed for attainment of scholarship.

- ***Health Initiatives:***
  - 45 children were given polio drops, on the 'Pulse Polio 'day, by the Mobile Crèches facilitators.

- ***Networking:***
  - After continuous interactions with the community by the members of NMPS, 150 labourers were motivated and got them registered.
  - Efforts were made to form a network with the local NGOs in the community and provide support in each other's objective achievements.

- ***Community Mobilization:***
  - After being spectator to the prevalent situations of basic facilities, community members came together to hold a 'dharna' at the Mathura Road to attract the attention of the Government.

➢ **July- September 2004**

- ***Community Awareness:***
  - During the survey of B-1 block, lot of children were found to be under sibling care, hence a meeting was organized with the parents on the needs of the children under 6 years of age.

- ***Community Mobilization:***
  - Public meeting was organized by the 'Prayatan' organization on the functioning of the PDS in the communities and the malpractices being carried out by its outlets. Mobile Crèches too mobilized the community to participate in the programme. Lot of people came forward with their problems.

- ***Networking and Lobbying:***
  - Supreme Court's order on the allotment of ICDS aanganwadis was well received by the people in the Non-Government sector, it was also important to inform the women of the community, who have been doing follow-up of the process rigorously. Hence a meeting was organized with the community people and the success was shared with them.
  - 22 children were linked to the local Government School. Regular follow-ups were done to ensure that respective children regularly attend the school or not.
  - Linkages with the neighbouring Dispensary were strengthened and more community

women were linked to it and to other NGOs as well, for common ailments and immediate help.

➢ **October2004- March 2005**

- ***Action Research:***
  - A training session was organized by the external resource person for the field staff and facilitators to carry out the focussed activity with the pregnant and lactating mothers.
  - An action plan was drawn as framework for the activities in future.
  - 20 meetings were held with the community to explain the objectives of the study.
  - A survey was done to identify the 250 families. Out of these 135 women was pregnant and 115 had young children less than 6 months of age.

- ***Networking and Lobbying:***
  - A signature campaign was floated to demand the dispensary in the area. Signatures of 50 people were collected and an application was drafted and sent for the Health Welfare Department.
  - For the opening of the ICDS centres, a follow-up the Mobile Crèches staff along with community women was done, by going to the CDPO's office.

- ***Event:***
  - A Khilta Bachhpan mela was organized in the month of March, the focus of which was the importance of ECCD in the life of the child.

➢ **April- September 2005**

- ***Community awareness:***
  - 10 Community meetings were organized to discuss the essence of ECCD with the help of various media like, Khilta Bachhpan and Neenv Charts, with an outreach of 154 community people.

- ***Capacity Building:***
  - The external resource person did training of the 7 birth attendants and newer facts were shared with the group.

- ***Action Research:***
  - Training of the facilitator was also done by Dr. Vandana Prasad on some of the life

threatening diseases, affecting the children below the 6 years of age, like diarrhoea, meningitis, etc.

- ***Community Mobilization:***
  - 53 people of labour community, from Madanpur Khadar, participated in rally at Jantar Mantar.
  - A fact finding survey was undertaken to identify BPL families, eligible for National Maternity Benefit Scheme. 3 families were identified and their applications were submitted to the Commissioner's Office.

- ***Networking and Lobbying:***
  - A public meeting was organized by all the local NGOs, for an interface with Police and PHC. 3000 people attended the meeting, which provided them with a platform to place their problems before the concerned authorities.
  - After much networking and lobbying, 47 aanganwadis were allotted to MK. Immediate steps taken following the order were to motivate the community women for applying for jobs in the programme.
  - A meeting with the local PHC was organized to request for conducting immunization, with an offer of help from facilitators, was refused due to lack of staff in the centre.

- ***Interface with media:***
  - 2 correspondents from the 'Janmat Television' visited the community, to gain an idea on the existing situation of electricity and ensured to put forward the public grievances at higher platform.

➢ **October- December 2005**

- ***Action Research:***
  - Dr. Vandana Prasad held regular health check-ups of the children in the centre. Many children were found to be malnourished and suffering from cold and cough.
  - A refresher training of the facilitators was done on ECCD.

- ***Community Mobilization:***
  - Team of Mobile Crèches involved in MK got the opportunity to participate in the various rallies and seminars on: Right to Information Act, importance of birth registration and rallies on Master Plan 2021, registration of labourers, violence against women and basic facilities in MK.

- ***Networking and Lobbying:***
  - The Government, in the community opened 2 aanganwadis, but soon they were transferred to the NGOs for running them.

- ***Community Awareness:***
  - A parents meeting was held with the scholarship students. This meeting included important issues like to increase the capability of the children, need for tuition, importance of education and problems regarding it were also discussed.

➢ **January- March 2006**

- ***Action Research:***
  - During an ongoing process of meeting 100% target for birth registration, the quarter saw our efforts for inching towards the target, with 194 children being registered.
  - Regular, monthly clinics were held, by Dr. Vandana Prasad. Some of the common ailments encountered were cold n cough, fever, diarrhoea, etc.
  - A grim situation of MK was presented in the community, and their comments were taken on the same.

- ***Community Mobilization:***
  - 30-35 aanganwadis opened in the community.

- ***Others:***
  - A survey was done to assess the situation of the education facilities in the community. It was found that 750 children are accessing schools in the vicinity with only 5 teachers to undertake the responsibility.
  - Documentation of the home based crèches operational in the area and the experiences of the Alumni with Mobile Crèches.

- ***Networking and Lobbying:***
  - 6-7 meetings were organized by the NMPS on Registration of then laborers, in which the people were motivated to get them registered. After which 25 people got them registered and have got their cards made.

➢ **April- June 2006**

- ***Action Research:***
  - During the course of Action Research, it was realized that the information collected on diarrhoea and supplementary diet, required further probing, hence, 2 more questionnaires were prepared.
  - Training of two newly appointed facilitators to prepare them for action research.

- ***Networking***
  - Efforts were made to form congenial relations with the mushrooming aanganwadis in the community.

- ***Others:***
  - Scholarships were provided to 21 children, in support of their education.

➢ **July- September 2006**

- ***Action Research:***
  - Analysis of the questionnaires based on diarrhoea management and supplementary nutrition.
  - 22 community families were motivated to get their children registered out of which 9 families got their children registered.
  - Since the beginning of the study there has been a constant decline in the number of families, hence it was found to be important to find the reasons for the same. During the analysis it was found the one of the most common reason is either the families have returned back to the village or they have shifted from the area.
  - After a continuous awareness generation and motivation 40 women have started using contraceptives and 3 have got the tubectomy done.
  - With the support from the neighbourhood Dispensary 145 children were immunized.
  - Regular clinics were held on monthly basis by the doctor along with referrals and counselling was done of mother on various issues related to growth and development of children.
  - Health report card: an initiative for keeping comprehensive records on growth the development of children with Mothers, even after completion of action research, was taken.

- ***Networking:***
  - Efforts were made to strengthen the relationship with the local aanganwadis.
  - A public meeting was organized in association with 2 other NGOs on public grievances.
  - 47 aanganwadis have opened in the community out of the 60 allotted for the area.

- ***Community awareness:***
  - 21 public meetings were organized with help of various media, based on the issues related to ECCD and the work being carried out by Mobile Crèches in the community.

- ***Others:***
  - A group of 28 adolescents was formulated, named Ekta, as the hobby club.

➢ **October'06- March'07**

- ***Action Research***
  - 30 families were found to be expecting again from the selected sample of 250 families. The similar series of forms are being administered with them and along with it the first round of action research is fast reaching completion, as the children are reaching the age of 18 months.
  - 153 children were immunized and 263 shots were administered. After observing a turnout of more that 50 children in each visit, the ANM stopped charging the transport fare, which they use to do earlier.
  - Our facilitators participated in the Pulse Polio Campaign, during which reached out 372 children in Madanpur Khadar.
  - Health clinics took place, 25 children were provided with an advice and prescriptions. Special emphasis was laid on the children in need or in grave conditions like acute diarrhoea and nephrotic syndrome.

- ***Advocacy And Networking***
  - Bal Adhikar Yatra: Mobile Creches full-fledgedly participated in the one of the biggest campaign carried out in the city on Children's Right to food and role of ICDS Aanganwadis in it. A rally in collaboration with other networks in the field were taken out in the city, touching much deprived areas.
  - Bal Adhikar Samwad: it was organized on 19th December 2006. 83 women, including ICDS workers from the community attended it. In the end a report prepared on the conditions of ICDS aanganwadis in the country to the Government.

- Bal Adhikar Yatra provided us with a window to explore our relationship with local NGOs. A series of meeting have followed since then and 7 NGOs are now regular members of the meetings. During the discussions some of the burning issues were recognized and planning is being done to address them.
- During the continuous interaction with EKTA group, a group of 28 children, revealed the lack of interaction with Fathers. Till now 3 meetings have been organized, which saw participation of 20 fathers in every meeting. The objective of such interface is to sensitize them of their role and impact on children.
- Meetings on action research: 5 meetings were organized in A-2 Block, with an outreach of 10- 15 women in each meeting. The objective of the meeting was to share the findings of the action research with the community. An interesting methodology was adopted, wherein the women were asked of their perception of children's health in the area and were depicted with help of chapatti diagrams then the findings were disclosed, a comparison on the situation made them realized the grim condition of children.
- Community Awareness: the energy and efforts of the staff members have also been directed towards making the larger community women aware of the Importance of Early Childhood Care and Development. A plan was developed to reach people in the area in a systematic manner. Out of the three blocks in Madanpur Khadar, one of them was selected for concentrated interventions. The sequence of interventions was planned and executed, which started with a media on importance of ECCD in the lives of young children, named "Khilta Bachhpan" the follow-up of the media was done with Neenv Charts, emphasizing on the growing needs of children and stakeholders fulfilling them these were then linked to the functional ICDS programme in the community.

- ***ICDS in the community***
  - 53 aagnawadis are now operational in Madanpur Khadar, though the Government has allotted 67.
- ***Others***
  - During this period, 20 new children received scholarship to pursue their studies further. Visits were paid to their households to collect their results and identify new children, in need for scholarship.

CASE STUDY

Case Study 1

Saira was 16 years old when she got married to Noor Islam and 18 when we came in contact with her during her first pregnancy. The family has been living in Subhash Camp of Dakshinpuri area for past 10 years along with Noor Islam's mother. Noor Islam is a plumber and earns Rs.2,500/- per month.

Saira was regular with her antenatal check-ups at AIIMS as well as at the dispensary van. During the research it was found the Saira was malnourished After a full gestational period the child was born at Safdarjung Hospital, but it was so weak that it had to be kept in nursery for 8 days. While the child was in hospital, he contracted pneumonia and later died.

Case Study 2

Geeta is a resident of A-2/2127, Madanpur Khadar Resettlement Colony. In the year 2000 when Nehru Place slums got demolished, she along with her husband and 3 children (2 boys and 1 girl) shifted here.

She was 16 years old when she got married to **Dayanu**, a tailor, and at the age of 17 she was expecting her first child.

Geeta had just delivered her 4th child, **Laxmi**, when she came in contact with Mobile Crèches and was included in the study .During the research it was found that Dayanu does not have a regular source of income and merely earns Rs.1500/- per month. At present they live in an open area where construction has not yet started. Geeta used to work when in Nehru Place as household maid but after coming to Khadar she could not continue with it.

Laxmi seemed to be weak when we first visited her, hence continuos interventions were made to improve her health. During our monthly visit to her house, it was found that she had developed severe swelling all over the body. Geeta was asked to visit the Mobile Crèches field centre after looking at the condition of Laxmi, the visiting Doctor diagnosed her of nephrotic syndrome and immediately asked her to visit a hospital.

Economic conditions of the family were grave, making it difficult for the family to arrange for such expenses. After much motivation and persistence Geeta took Laxmi to the hospital along with one of our facilitators. When the hospital doctors asked her to admit Laxmi, as the problem required regular monitoring, she brought her back.

Lot of counselling of Geeta was done after which she agreed to comply with the doctor's advice and the treatment. Mobile Crèches helped in gaining donation for the future treatment.

Laxmi was recovering well, there was no more swelling on the child. Now the biggest challenge was that for the child to remain well. Everything was going fine until one day when Mobile Crèches team visited her, it was found that Laxmi had developed ulcers in her mouth and dryness around the rectum, for which Geeta had already shown her to the mobile van of the Government Hospital visiting the area. But it seemed the medicines did not affect the child and she expired after 2 days.

Case study 3

Gulab is 38 years old. She has been living in Subhash Camp (slum community) for past 20 years with her husband. She got married to Sitaram when she was 18 years old and moved to Dakshinpuri with him. When Gulab came in contact with Mobile Crèches she was expecting her 11th child.

Her husband Sitaram is a daily wager and earns a meagre amount of Rs.2000/- per month. Gulab's elder daughter was not well for quite some time, but she refused to take to the doctor, but on the insistence she was taken to nearby DOT centre for check-up and there it was found that she had T.B.

During pregnancy, Gulab did not pay much attention towards antenatal care, but the delivery took place at Safdarjung hospital. The child, ***Akash*** was a low birth weight baby requiring lot of care and nurturing; but neither he was completely immunized nor he was exclusively breast fed. Gulab had only breast fed the child for 1 month and thereafter started with tea (dark without milk).

When Akash was three and half month old, he had acute diarrhoea and fever and was taken to the local doctor. Gulab was a superstitious woman, so she left her three month old child

under sibling care to visit their "religious leader". During that period, Akash could not survive the excessive dehydration and high fever and died.

Case study 4

Gayatri is 18 yeas old. She migrated to Delhi from Bihar when she got married. She was also a resident of Nehru Place and had shift to Madanpur Khadar Resettlement Colony when her slum was demolished. Her husband has a regular job and earns approximately Rs.4000/- per month, which supports 6 members in the family.

Gayatri was 17 years old when she got married and after 1 year, she conceived for the first time. During regular visits it was found that she was slightly casual towards her antenatal check-ups, adequate diet and intake of iron and folic acid during the crucial period of pregnancy.

When she completed her full term, Gayatri delivered her first baby at home with the help of a 'trained' birth attendant in the community. The child born was at 2 kgs. of birth weight.

After delivery Gayatri tried to feed her child but she did not succeed till the next day, after which the child went sleep and did not wake up. She felt the child might have choked to death.

परिवारिक, सामाजिक, आर्थिक स्थिति प्रपत्र

सामान्य परिचय

क्षेत्र कोड.....
घर काड.....

महिला का नाम.....

आयु .....

घर की भाषा .....

धर्म .....

क्षेत्र/जन्म स्थान .....

साक्षात्कार की तिथि .....

साक्षात्कार करने वाले का नाम .....

वर्तमान पारिवारिक स्थिति

क्रम सं.	सदस्यों के नाम	महिला से संबंध	लिंग पु./म.	आयु	शिक्षा स्तर कोड	गतिविधि
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

प्रतिवादी से सम्बन्ध	शिक्षा स्तर	गतिविधियां
स्वयं..... 1	आंगनवाड़ी बालवाड़ी	बालक.....1
पति / पत्नी.....2	क्रैश.....0	छात्र.....2
बेटा.....3	कभी भर्ती नहीं..... ...1	कामकाजी छात्र.....3
बेटी.....4	भर्ती लेकिन जाते नही.....2	व्यस्क जो कामकाजी न हो... 4
बहू.....5	भर्ती और जाते है.....3	
पोता–पोती.....6	(कक्षा / वर्ग बतायें).....4	कारण बतायें
भाई.....7	छोड़ दिया.....5	अपंग / बीमार / अन्य बिना तनख्वाह का.....
बहन.....8	ब्रिज कोर्स.....6	
अन्य संबन्धि.....9	केन्द्र.....7	घरेलू काम / बाल देख रेख..... 5
सम्बन्धि.....10	निरक्षक व्यस्क.....8	कामकाजी (तनख्वाह सहित)..... 6
	प्राथमिक (व्यस्क) तक.....9	
	माध्यमिक (व्यस्क).....10	
	माध्यमिक से उपर.....11	
	अन्य बताये.....12	

सामान्य परिचय

1. लोग यहां कब से रह रहे है ?
- 0 – 5 वर्ष
- 5 – 10 वर्ष
- 10 – 15 वर्ष
- 15 – 20 वर्ष

2. आप पहले कहॉ रहते थे, आप यहां क्यों आये ?
- रोजगार
- इलाज के लिए
- बस्ती टूटने के कारण
- पढाई के कारण
- कर्ज उतारने के लिए
- अन्य

3. आपके परिवार वाले आजीविका के लिये क्या करते है और कितना कमाते है?

परिवार के सदस्य का नाम	व्यवसाय	आयु	कार्य समय	काम का स्तर

- प्रतिमाह, प्रतिदिन आदि –
- पीस रेट पर –

4. उपर इसके अतिरिक्त क्या कोई अन्य पारिवारिक आय के साधन है?
- मकान का किराया
- खेती बाड़ी से आमदनी
- अन्य

- शादी के समय आपकी आयु क्या थी?
- अपने पहले बच्चें के जन्म पर आपकी आयु क्या थी?
- शादी के कितने वर्षो बाद आपका पहला बच्चा हुआ?
- आप कितनी बार गर्भवती हुई?
- क्या आप इस समय गर्भवती है? अगर हां तो कितने माह का गर्भ है?
- क्या आप कोई गर्भ निरोधक तरीका इस्तेमाल करती है? जैसे– गोलियॉ, नसबंदी, परहेज, निरोध, कॉपर–टी अन्य।

पिछली गर्भावस्था के दौरान क्या–क्या किया व बाल देख–रेख की पूर्व जानकारी का स्तर–

महिला का नाम ———————— परिवार के सदस्यों की संख्या————————

उम्र———— घर कोड ————————————————

बस्ती का नाम————————————————

1. आपने क्या–क्या चैक–अप करवाये–

(क) पेशाब की जॉच ☐ (घ) वज़न ☐

(ख) खून की जॉच ☐ (ड़) अल्ट्रा साउन्ड ☐

(ग) टेटनस का टीका ☐ (च) रक्तचाप की जॉच ☐

2. बच्चा कहॉ पैदा हुआ–

घर ☐ प्रशिक्षित दाई ☐ अस्पताल ☐

3. बच्चे का वज़न कितना था।

4. बच्चे का जन्म पंजीकरण हुआ या नही।

5. बच्चे का वज़न पहले साल में कितनी बार नापा गया–

एक बार ☐ दो बार ☐ तीन बार ☐

6. सरकार से मातृत्व भत्ता मिला या नहीं।

हॉ ☐ कितना ☐ नहीं ☐ क्यों नहीं ☐

7. क्या आपने आयरन फोलिक एसिड गोली खाई–

हॉ ☐ नहीं ☐ क्यों नहीं ☐ कब तक खाई ☐

8. पहला दूध पिलाया ।

हॉ ☐ नहीं ☐ कब पिलाया ☐☐

9. पानी व खाना दिये बिना सिर्फ स्तनपान कब तक कराया। माह ☐

10. उपरी आहार कब भुरू किया

6 माह ☐ 8 माह ☐ 1 वर्ष ☐ अन्य ☐

11. आहार शुरू करने के बाद भी आपने स्तनपान जारी रखा कब तक? समय

12. बच्चे को टीके लगे है, कितने लगे है, कार्ड है या नही स्वयं कार्ड देखकर लिखना है?

13. विटामिन– **A** दिया या नहीं हॉ ☐ नहीं ☐

14. बच्चे को पैदा होने पर कब नहलाया?

तुरन्त ☐ एक दिन ☐ दो दिन ☐ तीन दिन ☐

15. बच्चा पैदा होने के बाद परिवार नियोजन कब अपनाया ?

40 दिन बान ☐ 3 माह ☐ 6 माह ☐ 1 वर्ष ☐

16. दस्त को कैसे पहचाना ?

17. दस्त होने पर कैसा भोजन दिया ?

18. दस्त होने पर क्या उपचार किया ?

16. दस्त को कैसे पहचाना ?

17. दस्त होने पर कैसा भोजन दिया ?

18. दस्त होने पर क्या उपचार किया?

19. ओ.आर.एस. घोल बनाना आता है या नहीं ? पूछो कैसे बनाते है?

हॉ ☐ नहीं ☐

20. छोटे बच्चे के नाखून बाटते हो या नहीं स्वयं देखकर लिखना है?

21. खाना खिलाते समय हाथ धुलात है या नहीं ?

वर्तमान में गर्भवती महिला की जानकारी हेतु प्रपत्र

क्षेत्रीय कोड नं. –
दिनांक–

- गर्भवती महिला का नाम _____
- कौन सा महीन है _____
- अस्पताल में कहॉ नाम लिखवाया

सरकारी ☐ प्राईवेट ☐ घर पर

- आपने कौन–कौन सी जॉच कराई है।

पेशाब ☐

खून ☐

रक्तचाप ☐

वज़न ☐

(लिखें या करें) ☐

गर्भ में बच्चें की स्थिति ☐

टीकाकरण ☐

आयरन ☐

- घर मे प्रसव किससे करवओगे ?
  प्रशिक्षित दाई ☐

  समुदाय की बुर्जुग महिला ☐

आहार

– आप पूरे दिन मे क्या–क्या खाते है।

– नाशते मे

– दोपहर के खाने में

– शाम के नाशते में

– रात के खाने मे

– भोजन सम्बन्धित भ्रांतियां

– दोपहर के खाने के बाद आराम करती हो या नहीं।

क्या देखेगें

- चेहरा पीला
- सफाई
- पैरों में सूजन
- पेट का आकार
- सुस्त है
- चुस्त है
- खाना कैसा खा रही है
- वज़न
- घर का माहौल

<u>क्या जानकारी देंगे</u>

- पेशाब में जलन
- कौन–कौन सी जॉच करवनी है।

लोहायुक्त

1. गुड़
2. खजूर
3 हरी सब्जी पत्ते
4 लोहे की कढाई मे पकाए
5 इसके साथ खटटी चीजे जैसे– नींबू, संतरा, आंवला आदि खाएं।

- खाने की जानकारी (डेढ़ गुना खाना–खाना है खाली पेट न रहना)
- आयरन फॉलिक एसिड की जानकारी देनी है (100 गोली)
- सफाई
- आराम (एक घन्टा दोपहर में आराम अव य करें)
- स्वास्थ्य केन्द्र कहॉ इसकी जानकारी देना
- टी.टी. टीकाकरण का दिन बताना (3–8 महीने के बीच 2 टीके)
- गर्भवती महिलाओं के जॉच का कौन– सा दिन है बताना
- नौ माह के गर्भ के दौरान दी जाने वाली जानकारियॅा।

– जन्म से तुरन्त बाद बच्चें को नहलाना नही है।
– पहले दूध का महत्व
– सिर्फ स्तनपान का महत्व
– बच्चे को कई लोगों के हाथ मे न दें, न ही चुमें
– बच्चे को लेने से पहले हाथ धोना

- क्या कदम लिए :
- क्या अनुसरण किया :
- विशेष परिस्थिति मे क्या कदम लिया :

सुपरवाईजर के हस्तक्षर व दिनांक

सुपरवाईजर टिप्पणी–

गर्भवती महिला का वजन
बढना चाहिए
8–12 किलो ग्राम

कैसे लेटे
बायीं ओर घुटने मोर कर लेटें।

खतरा
1 अधिक रक्तस्राव
2 पेट दर्द
3 तेज बुखार

कोई दवा डॉक्टर के सलाह के बिना न लें।

प्रसव के तुरन्त बाद ली जाने वाली जानकारी एवं अवलोकन प्रपत्र

1 प्रसव कहॉ हुआ घर ☐ अस्पताल ☐

2 प्रसव किसने किया प्रशिक्षित दाई ☐ डॉक्टर ☐ अन्य ☐

3 प्रसव नार्मल ☐ आपरेशन ☐

4 प्रसव के दौरान पॉच विशेष बातों पर ध्यान दिया?

नया ब्लेड	नया धागा	साफ जगह	साफ हाथ	साफ नाल
☐	☐	☐	☐	☐

5 प्रसव के उपरान्त खाना कब खया ?

कुछ घण्टे बाद ☐ 1दिन बाद ☐ तीन दिन बाद ☐ अन्य ☐

6 दर्द अधिक तो नही ? हॉ / नही।

7 रक्त स्राव अधिक तो नहीं हॉ / नही।

8 पेशाब व भौच सामान्य है हॉ / नही।

9 बुखार तो नहीं है हॉ / नही।

10 अन्य कोई परेशानी हॉ / नही।

बच्चा

1 पैदा होत ही रोया हॉ / नही।

2 पूरे भारीर का निरीक्षण रंग ☐ अंग ☐ सांस ☐ वजन ☐

3 बच्चे को पहला दूध कब पिलाया घण्टे ☐ दिन ☐ अन्य ☐

4 बच्चे का वजन जन्म पर तुरन्त ☐ 1 दिन बाद ☐ 1 सप्ताह बाद ☐

5 बच्चे को कब नहलाया

घन्टे ☐ 1दिन बाद ☐ 3 दिन बाद ☐ अन्य ☐

6 दूध पिला रहे है कि नहीं हॉ / नही।

7 दूध के साथ और क्या पिला रहे है।

पानी ☐ घुटटी ☐ अन्य ☐

जानाकारी (चर्चा)

- मॉ का पहला दूध, कोलोस्ट्रम व (Excusive milk) सम्बन्धी।
- दूध विलाने का तरीका
- मालिश
- नहलाना, मौसम अनुसार कपड़े
- बच्चे के साथ स्पर्श (Early Stimulation) प्यार, दुलार, बातचीत, उत्प्रेरणा।
- बच्चे का बिमारी से बचाव– हाथ धोकर बच्चे को उठाना, चूमना नहीं ऑख में काजल (नहीं)

टीकाकरण–

- जन्म पर बी.सी.जी., पोलियो, हैपीटाइटिस बी।
- जन्म पर बच्चे का सामान्य पीलिया होता है, सुबह की पहली धूप बच्चे को दें एक सप्ताह तक ठीक न हो तो डॉक्टर को दिखायें।

परिवार नियोजन सम्बन्धी जानकारी

- परिवार नियोजन के लिये तरीके अभी से सोचे।
- गर्भ–निरोधक गोली नहीं खानी क्योंकि दूध के द्वारा बच्चे पर दवाई का असर पड़ता है।
- कंडोम का प्रयोग करें।
- डेढ माह बाद कॉपर –टी लगवा सकती है।

अन्य जानकारी

- बच्चे का जन्म प्रमाण पत्र भीघ्र बनवाये।
- कहा बनता है (मार्गदर्शन)
- मातृत्व भत्ता (Maternity benefit) स्कीम क्या है।
- कहॉ से मिलता है।
- किसे मिलता है।
- कितने बच्चों पर मिलता है।

विशेष परिस्थिति में क्या कदम उठाया –

पिछले कदम का अनुसरण–

नया कदम क्या उठाया–
दिनांक–
प्रपत्र भरने वाले का नाम–

हस्ताक्षर–

सुपरवाइजर की टिप्पण

हस्ताक्षर दिनांक–

जन्म के 15 दिन बाद विज़िट में जानकारी हेतु प्रपत्र

घर कोड नं. ☐

दिनांक – .....।

बच्चे का नाम– ..... माँ का नाम–.....

जन्म तिथि ☐

लिंग ☐

वज़न

जन्म के समय ☐

15 दिन बाद ☐

टीकाकरण

बी.सी.जी.	जन्म का टीका	हैपेटाइटिस बी	पोलियो खुराक
☐	☐	☐	☐

माँ ने पहला दूध पिलाया

एक घण्टे बाद ☐

छः घण्टे बाद ☐

तीन दिन बाद ☐

छः माह तक केवल माँ का दूध देना।

पीलिया है या नहीं

बच्चे की नाभि ठीक है

माँ का दूध पर्याप्त मात्रा में आ रहा है

माँ को कोई तकलीफ तो नहीं है

माँ का भोजन

रक्त स्राव कम हुआ या नहीं

क्या देखेंगे

बच्चा स्वस्थ है

बच्चे का रंग, अंग, सांस, वज़न

बच्चे को कपड़े पहनाए हैं

बच्चे की सफाई का ध्यान है या नहीं

पीलिया है या नहीं

जन्म के टीक को देखना

15 दिन में अस्पताल लेकर गए गए या नहीं

दूध पिलाने का तरीका

मॉ व बच्चे को बुखार तो नहीं है।

मॉ को दर्द तो अधिक नहीं है

मालिश– मॉ / बच्चे की

ध्यान योग्य बातें

1. 15 दिन पर पीलिया न हो
2. बच्चे का वज़न जन्म के वज़न से बढा हो
3. आराम से बच्चा दूध पी रहा है।

<u>नवजात शिशु में बीमारी के लक्षण</u>

1. दूध न पीना
2. सुंस्त या ढीला होना
3. बच्चे का भारीर ठंडा महसूस होता है।
4. सांस का 60 बार प्रति मिनट से अधिक चलना या पसली चलना
5. बुखार होना।

क्या जानकारी देंगे

- सामान्य पीलिया है या नही । है तो डॉक्टर को पास लें जाएं।
- छः माह तक केवल मॉ का दूध देना, पानी, भी नहीं देना।
- टीकाकरण की जानकारी देना।
- बच्चे को गर्म रखें।
- मॉ को भोजन की जानकारी देना।
- बच्चे का वज़न करना।
- बच्चे की सफाई का विशेष ध्यान रखना।
- जन्म पंजीकरण की जानकारी देना।
- 15 दिन पश्चात बच्चे को अस्पताल ले जाएं। बच्चे की नाभि में कोई संक्रमण नज़र आ रहा है तो डॉक्टर को दिखाएं।
- परिवार कल्याण के माध्यमों कीक जानकारी देना। निरोध, कपर–टी 1½ माह बाद लगवाएं।

- मातृत्व भत्ते की जानकारी देना।
- विशेष परिस्थिति में क्या कदम उठाए।
- पिछले कदम का अनुसरण
- नया कदम क्या उठाया।

प्रपत्र भरने वाले का नाम–

हस्ताक्षर–

दिनांक–

सुपरवाइजर की टिप्पणी–

हस्ताक्षर–

दिनांक–

1½ माह के बच्चों का अवलोकन प्रपत्र

दिनांक –

घर कोड नं0

महिला का नाम –

उम्र –

लिंग –

बच्चे का नाम –

जन्म तिथि –

अभिवृद्धि

लम्बाई –

वज़न –

स्वास्थ्य एवम पौष्टिक आहार

टीकाकरण –

टीका	दिनांक	विवरण
हैपिटाईटिस B.		
D.T.P. & Polio I		
II		
III		
B.C.G.		

बिमारी की जानकारी – दस्त और निमोनिया

गर्भनिरोधक माध्यमों की जानकारी – निरोध, कॉपर– टी, मालाडी

केवल मॉ का दूध पिलाना। हॉ नहीं

<u>विकास :</u>

- हाथ पैर हिला रहा है या नहीं
- पेट पर लिटा कर देखन
- सिर उठाता है या नहीं
- मॉ की भाक्ल देख रहा है या नहीं
- नज़र टिक रही है या नहीं
- तेज आवाज परी सुन रहा या नहीं
- मुस्कुरा रहा है या नहीं
- अुंगुली पकडने का प्रयास करता है या नहीं

ध्यान देने योग्य बातें –

- जन्मघुटटी भाहर, गुड़ का पानी, ग्राइपावाटर, पानी नहीं देना चाहिए।
- बिना हाथ धोए बच्चे को गोद में न लें।
- बच्चे के मुख का चुम्बन न लें।
- बच्चे के भारीर एवं वातावरण की सफाई का ध्यान रखें।
- स्तन पान कराते समय मॉ अपने हाथ व स्तनों को धोए।
- दूध पिलाकर कंधे से लगाकर डकार दिलवाना

सुपरवाइजर की टिप्पणी

प्रपत्र भरने वाले का नाम
व हस्ताक्षर

2½ माह के बच्चों का अवलोकन प्रपत्र

दिनांक – घर कोड नं0

महिला का नाम –

उम्र –

बच्चे का नाम – लिंग –

जन्म तिथि –

अभिवृद्धिः–

वज़न –

अभिवृद्धिचार्ट भरना ह –

<u>स्वास्थ्य एवम पौष्टिक आहार</u>

टीकाकरण –

टीका	दिनांक	विवरण
हैपिटाईटिस B.		
D.T.P. & Polio I		
II		
III		

<u>खान पान</u>	केवल मॉ दूध	हाँ	नहीं
<u>बिमारियॉ</u>	खॉसी, जुकाम, दस्त, निमोरिया, उल्टी, बुखार,		
<u>गर्भ निरोधक</u>	माध्यमों की जानकारी (निरोध, कॉपर टी, माला डी)		
<u>विकास</u>	सिर संभाल पा रहा है या नहीं		
	अब पूरी तरह मुस्कुरा रहा है		
	आवाज निमालना नज़र में स्थिरता।		

ध्यान देने योग्य बातें –

- अतिरिक्त पोलियों की खुराक पिलाएं
- विशेष परिस्थिति में क्या कदम उठाए

a. पिछले कदम का अनुसरण b. नया कदम क्या उठाया

दिनांक – प्रपत्र भरने वाले का नाम–

सुपरवाइजर के हस्ताक्षर व टिप्पणी –

3½ –4 माह के बच्चों का अवलोकन प्रपत्र

दिनांक –

घर कोड नं0

महिला का नाम –

उम्र –

बच्चे का नाम –

लिंग –

जन्म तिथि –

अभिवृद्धिः–

वज़न –

अभिवृद्धिचार्ट भरना –

<u>स्वास्थ्य एवम पौश्टिक आहार</u>

टीकाकरण –

टीका	दिनांक	विवरण
हैपिटाईटिस B.		
D.T.P. & Polio I		
II		
III		

<u>खान पान</u> केवल मॉ दूध

6 माह के बाद उपरी आहार देना मॉ के दूध के साथ

<u>बिमारियॉ</u> खॉसी, जुकाम, दस्त, निमोरिया, उल्टी, बुखार,

<u>गर्भ निरोधक</u> माध्यमों की जानकारी (निरोध, कॉपर टी, माला डी)

<u>विकास</u> स्थिर होतो है

जोर–जोर से आवाज निकालता है

कोई भी आवाज होने पर इधर–उधर गर्दन घमाता है

झुनझुन अपने आप पकडता है
मॉ की पहचान हो जाती है।
बच्चे का पलटने की कोशिश करना या पलटना

घ्यान देने योग्य बातें–

- भारीर का जोड़ में सफाई जैसे– बगल, अंगुलियों के बीच में, कान के पीछे, जॉघ, गर्दन, नाखून काटना
- दूध पिलाकर कन्धे से लगाकर डकार दिलवाना
- बच्चे से बातचीत करना
- मौसम अनुसार कपड़े पहलनाना
- आयु अनुसार खेल खिलौने
- दूध पिलाने से पूर्व हाथों व स्तनों की सफाई

विशेष परिस्थिति में क्या कदम उठाए

पिछले कदम का अनुसरण

नया कदम क्या उठाया

दिनांक–

प्रपत्र भरने वाले का नाम–

सुपरवाइजर के हस्ताक्षर व टिप्पणी –

6 माह के बच्चों का अवलोकन प्रपत्र

दिनांक –

घर कोड नं0

महिला का नाम –

उम्र –

बच्चे का नाम –

लिंग –

जन्म तिथि –

अभिवृद्धिः –

वज़न –

लम्बाई –

अभिवृद्धिचार्ट भरना –

<u>स्वास्थ्य एवम पौष्टिक आहार</u>

टीकाकरण –

टीका	दिनांक	विवरण
B.C.G. III **पेलियो खुराक**		
D.T.P.I		
II		
III		
हेपेटाईटिस I		
हेपेटाईटिस II		
हेपेटाईटिस III		

टीकाकरण– हेपेटाईटिस बी की 3rd Dose लगी है या नहीं ?

6 माह तक – केवल मॉ का दूध

उपरी आहार– विस्तार से समझाना

खॉसी जुकाम के उपचार

<u>विकास–</u>

1. सहारे से बैठता है या नहीं	हाँ	नहीं
2. आवाज की ओर मुँह घुमाता है या नहीं	हाँ	नहीं
3. वस्तुओं को हाथ बढाकर पकडता है या नहीं	हाँ	नहीं
4. वस्तु को मुँह में डालना	हाँ	नहीं
5. छोटे चीज़ पर नज़र टिकाना	हाँ	नहीं
6. परिवार के सदस्यों को पहचानता हैं या नहीं	हाँ	नहीं
7. क्या पीठ के बल लेटकर हाथ पैर चलाता है या नहीं	हाँ	नहीं

ब बा, आ आ की आवाज, सुनना, हॅसना, बड़बडाना, खिलखिलाना, आवाज में उतार–चढ़ाव, नाम की पहचान ताली की नकल करता है या नही।	हाँ	नहीं

हाथों व पैरों को देखना
विशेष परिस्थिति में क्या कदम उठाए
पिछले कदम काक अनुसरण
नया कदम क्या उठाया
प्रपत्र भरने वाले का नाम–

हस्ताक्षर–
दिनांक–
सुपरवाइजर के हस्ताक्षर

सुपरवाइजर के टिप्पणी

9 माह के बच्चों का अवलोकन प्रपत्र

दिनांक –

महिला का नाम –

बच्चे का नाम –

जन्म तिथि –

घर कोड नं0

उम्र –

लिंग –

अभिवृद्धिः–

वज़न –

लम्बाई –

दांतों का विकास –

अभिवृद्धिचार्ट भरना –

<u>स्वास्थ्य एवम पौष्टिक आहार</u>

टीकाकरण

खसरा	
विटामिन –A	

<u>खान– पान</u> : अर्द्ध ठोस आहार (धुटा हुआ दिलिया खिचड़ी, मसली हुई सब्जियॉ, सूजी की खीर, उबला आलू व अंडा अन्य) दिन में चार या पॉच बार देना।

<u>बिमारी :</u> खसरे की जानकारी देना, डायरिया

<u>विकासः</u>

- लिटाने पर उठाकर बैठ जाता हैं
- बिना सहारे के बैठ जाता हैं।
- अंगुली से छोटी वस्तु पकड़ना

- घुटनों के बल चलता है।
- स्हारे से खड़ा हो जाता है।
- वस्तु को पकड़ना व फेंकना
- एक ही क्रिया को बार– बार दोहराना।
- वस्तु को एक से दूसरे हाथ में देना
- वस्तु उठाकर मुंह में डालना

ध्यान देने योग्य बातें:–

i सुरक्षा का ध्यान (आग, पानी, दवाईयॉ, अकेला न छोड़े)
ii आयु अनुसार खिलौने देना एवं खेल करवाना
iii बच्चें से बातचीत करना
iv मौसम के अनुसार कपड़े पहनाना
v सफाई का ध्यान

विशेष परिस्थिति में क्या कदम उठाए

पिछले कदम का अनुसरण

नया कदम क्या उठाया

प्रपत्र भरने वाले का नाम–

दिनांक–

सुपरवाइजर के हस्ताक्षर–

सुपरवाइजर की टिप्पणी–

12 माह (1 वर्ष)के बच्चों का अवलोकन प्रपत्र

दिनांक –

महिला का नाम –

बच्चे का नाम –

जन्म तिथि –

घर कोड नं0

उम्र –

लिंग –

अभिवृद्विः–

वज़न –

लम्बाई –

अभिवृद्विचार्ट भरना –

<u>स्वास्थ्य एवम पौष्टिक आहार</u>

टीकाकरण

खसरा	
विटामिन –A	

<u>खान– पान</u> : घर में बना भोजन बिना मिर्च मसाले का दिन में चार– पॉच बार मॉ के दूध के साथ।

बिमारी : दस्त, बुखार, जुकाम, निमोनिया।

<u>विकासः</u>

- ताली बाजाता हैं, नकल करता है।
- अपनी इच्छा प्रकट करता है।
- बिना सहारे अच्छी तरह खड़ा हो सकता है।
- पापा मामा कीह सकता है।

- चलना शुरू कर देता है।
- नाम सुनकर मुड़ता है।
- अंगूठे और अंगुली सं पकड़ना
- ताली बाजाता है।
- कटोरी से पीना।
- टाटा करना
- पैरों पर झुलाना।
- लुका–छुपी का खेल
- मुँह पर कपड़ा डालकर उठाना– बच्चा हंसता है।
- आयु अनुसार खिलौने
- चीजें दूर रखकर उठाना।

ध्यान देने योग्य बातें : –

i मौसम अनुसार कपड़े
ii बच्चें को अलग बर्तन में खाना देना।
iii खाना बदल–बदल कर देना।

पिछले कदम का अनुसरण

नया कदम क्या उठाया

दिनांक–
प्रपत्र भरने वाले के नाम–

सुपरवाइजर के हस्ताक्षर–

सुपरवाइजर की टिप्पणी–

18 माह के बच्चों का अवलोकन प्रपत्र

दिनांक –
महिला का नाम –
बच्चे का नाम –
जन्म तिथि –

घर कोड नं0
उम्र –
लिंग –

अभिवृद्धिः–

वज़न –
लम्बाई –
अभिवृद्धिचार्ट भरना –
दांत –

<u>स्वास्थ्य एवम पौष्टिक आहार</u>

टीकाकरण –

M.M.R.	
D.T.P. बूस्टर	
विटामिन –A	

<u>खान– पान</u> :

<u>बिमारी</u> :

<u>विकासः</u>

- सहारे लेकर सीढी चढ़ना
- कुर्सी पर चढ़ना

- घर के काम की नकल करता है।
- छोटे–छोटे शब्द स्पष्ट बोलता है।
- शब्दों पर जोर देकर बोलता है।
- अपनी बात को शब्दों में समझता है, वाक्य पूरा नहीं बोल पाता।
- स्वयं खाना खाने की कोशिश करता है।
- पन्ना पलटना
- पेंसिल चलाना
- लगातार बक–बक करना
- 5–7 शब्द बोलना
- शरीर के कुछ अंगों की जानकारी देना
- चम्मच मुँह में डालना
- जूता उतारना

विशेष परिस्थिति में क्या कदम उठाए

पिछले कदम का अनुसरण

नया कदम क्या उठाया

प्रपत्र भरने वाले का नाम–

हस्ताक्षर–

दिनांक–

सुपरवाइजर के हस्ताक्षर–

सुपरवाइजर की टिप्पणी–

आंगनवाड़ी केन्द्र पर अपने बच्चे का नियमित वज़न लें

वृद्धि चार्ट

वृद्धि सूचक
अच्छी
खतरनाक
अत्यधिक खतरनाक

सामान्य
श्रेणी–1 (हल्की)
श्रेणी–2 (मध्यम)
श्रेणी–3 (गम्भीर)
श्रेणी–4 (गम्भीर)

1 किलोग्राम
500 ग्राम
100 ग्राम

तुरन्त आंगनवाडी कार्यकर्ता/ए एन एम से बात करें

भार किलोग्राम में

जन्म का वज़न

दस्त

- अधिक बार स्तनपान कराएं
- अधिक मात्रा में तरल पदार्थ दें
- जीवन रक्षक घोल दें
- सामान्य आहार देना जारी रखें
- यदि पानी जैसे दस्त न बंद हों तो बच्चे को स्वास्थ्य केन्द्र ले जाएं

बुखार

- यदि बुखार तेज़ है तो हाथ–पैरों और माथे पर गीली/ठंडी पट्टियां रखें और बच्चे को स्वास्थ्य केन्द्र ले जाएं

उग्र श्वसन संक्रमण

- यदि बच्चे की सांस तेज–तेज़ चल रही हो और/या उसे सांस लेने में तकलीफ हो तो उसे स्वास्थ्य केन्द्र ले जाएं

+बीमारी के दौरान देखभाल+

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